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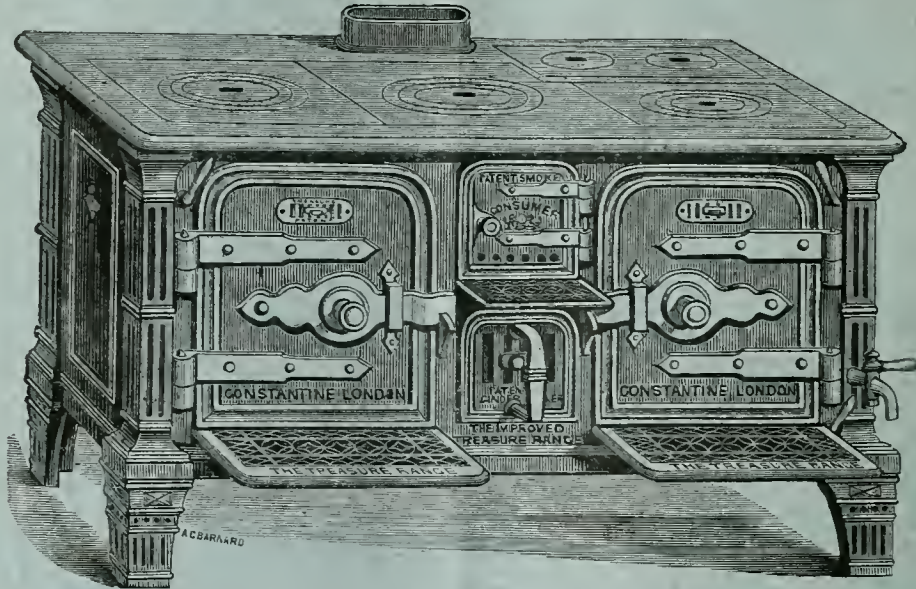
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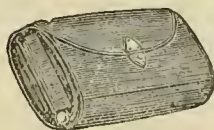
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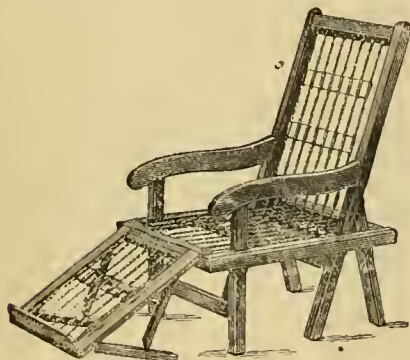
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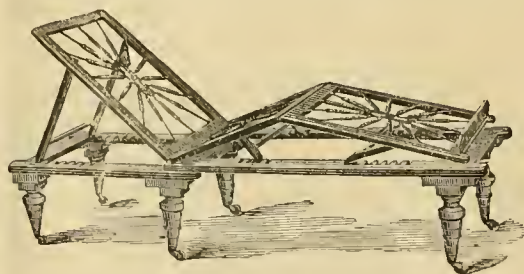
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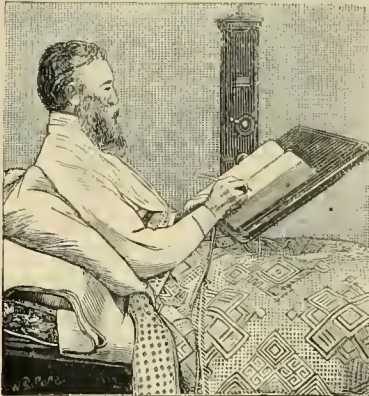
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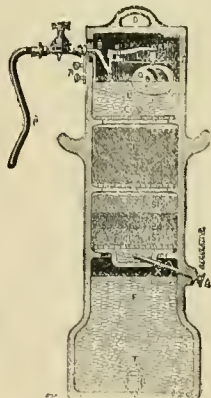
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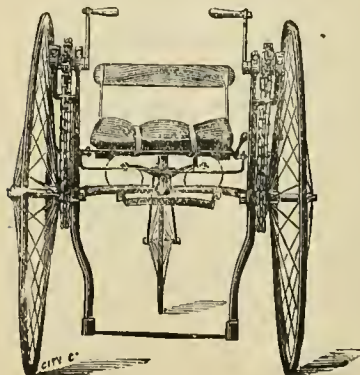
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ARTICLE 784.

CORRADI ON THE CONTAGION OF PHTHISIS.

AT the International Congress of Hygiene of Geneva (*Il Pisani*, Disp. 4, 5, 6) Professor Corradi proposed the following conclusions.

1. The belief in the contagion of phthisis dates from the most remote antiquity, and held its ground not only in the opinion of the vulgar, but as a scientific doctrine.

2. In the second half of the last century this belief reached its apogee, probably because the disease assumed a frequency unknown in the past. In most places, the State was obliged to intervene and take measures, in the interest of the public health, with the scope of impeding the diffusion of the contagion.

3. In the first half of our century, on the contrary, the doctrine of contagion lost ground; anatomy and pathology being in the ascendant, etiology suffered.

4. In the last few years only has experimental pathology again taken up the question, endeavouring to give to the doctrine of contagion the support of experiments on the inoculation of tubercle. Further, it is believed possible to demonstrate that the poison is represented by a bacillus.

5. The problem so clearly put by experiment must be solved by clinical observation. To pathology it belongs to reconcile this doctrine with the fact of predisposition and heredity.

6. But if contagion and transmission be possible, the conditions yet remain to be determined.

7. Meanwhile, hygiene must comport itself in regard to phthisis as it would with a suspected malady, that is, one capable of being communicated or transmitted under certain circumstances.

8. Especially must it consider the conditions of cohabitation. If cohabitation be less constant and intimate there will be less risk run, and the exhalations of the sick, which, apart from any specific action, undermine the health and predispose to phthisis, will be avoided.

9. Although it is not certain that tuberculosis can be communicated in articles of food, it is nevertheless prudent to avoid the flesh and milk of phthisical animals.

10. It is necessary to exercise great care in the choice of vaccine lymph, whether from the calf or humanised.

11. The institution of special hospitals, or at least of special wards, is strongly to be recommended.

12. The results of new studies and researches, undertaken with the scope of determining the conditions and means of transmission of tuberculosis, will indicate the more special prophylactic measures it will be necessary to take.

13. Whatever opinion is professed as to the nature of phthisis pulmonalis, no one doubts the great advantage the resistance of the organism has in the struggle; and therefore one of the greatest obstacles to the diffusion of this scourge of civilisation is to be expected from the practice of hygiene, which assures the moral and physical well-being of the population.

G. D'ARCY ADAMS, M.D.

ARTICLE 785.

VASSILIEFF ON CALOMEL AND MICRO-ORGANISMS.

DR. VASSILIEFF has recently published some interesting researches into the action of calomel on the contents of the intestines.* He alleges that he has proved that this drug leaves the gastric, hepatic, and pancreatic secretions absolutely unchanged; but prevents certain processes of retrogressive metamorphosis and putrefaction, by destroying bacteria and micrococci naturally present in the alimentary canal. Hoppe-Seyl-r has rightly attributed the bright green colour of 'calomel stools' to the presence of unaltered bile in the feces. Under normal conditions, the colouring matter of bile is destroyed in the process of digestion; but, Dr. Vassilieff argues, calomel prevents this destruction, and the colouring material remains to give to the faeces their peculiar hue under these conditions. The pancreatic secretion is peculiarly complicated, and particularly liable to very rapid decomposition, with the consequent formation of indol and allied products. Calomel entirely prevents this change, and also alters the characters of the gases evolved in the process of pancreatic digestion, especially diminishing the evolution of carbonic acid. Experiments on artificial pancreatic digestion proved that, when calomel was mixed with pancreatic juice, proteids, starch, and fats were all acted upon in the usual manner, trypsin, amyllopsin, and steapsin being unaffected by the drug, but indol, long recognised as a product of decomposition, is not formed.

Dr. Vassilieff, in a further series of experiments, found that this prevention of decomposition was due to the distinctly aseptic and antiseptic properties with which calomel is endowed. He discovered that it prevented the formation of bacteria and micrococci in food removed from the intestines and freed from these micro-organisms, and that it also destroyed them where they were present. Dr. Vassilieff administered fifteen grains of calomel to a dog, in two equal doses, and killed the animal a few hours after the second dose. The contents of the intestine were collected and analysed with every precaution. No indol nor phenol could be found, but much leucin and tyrosin, generally destroyed at an early stage of digestion, were detected. This experiment appears to have been repeated more than once. Other experiments, with cheese, showed that calomel prevents butyric acid fermentation.

Dr. Vassilieff's experiments are obviously of great interest from their therapeutic, clinical, and physiological aspects. They also turn attention to the significance of the relation of micro-organisms normally present in the contents of the alimentary canal to the process of digestion, in which they actually appear to play an important part. The processes which produce indol appear to be set going by these germs, and can hardly be reckoned as morbid, nor do they go on for no purpose; and it is clear that we are not meant to keep ourselves for all our lives under a course of calomel, so that the gastric, biliary, and pancreatic juices alone may act upon the food which we eat. We hear much about the harm which some species of protophytes can do, but we should like to hear more of the good which others effect, the true use for which they are present in the animal economy. Future science

* Ueber die Wirkung des Calomel auf Gärungsprozesse und das Leben von Mikro-Organismen. *Zeitschr. für Physiol. Chemie*, 1882, Vol. vi.

may show that they are not only the chief agents in most forms of infection and decomposition, but that they are essential in more normal and constructive vital processes.

ALBAN DORAN.

ARTICLE 786.

KOCH ON PUBLICATIONS DIRECTED AGAINST THE SIGNIFICANCE OF THE BACILLUS OF TUBERCLE.

IN an article in the *Deutsche Medicinische Wochenschrift*, March 7, Dr. Koch expresses surprise that more criticism has not come from the side of pathological anatomy, and that what has been written has been chiefly from a clinical point of view. And here most of the observations have been made with so little experience in microscopic work, and so little precaution to avoid errors, that Koch would not notice them at all, were it not that they appear to receive more widespread attention than they deserve.

He begins with the American investigators, who have made some remarkable admissions. Ephraim Cutter, in the *American Medical Weekly*, considers the tubercle-bacilli to be embryonic forms of the mycoderma aceti, found already by H. Salisbury in the blood. Rollin R. Gregg considers phthisis to consist in a diminution of albumen in the blood. He then imagines that threads of fibrin are formed, which have been mistaken for bacilli. He appears to have considered microscopical investigation on his own part superfluous. Schmidt, in the *Chicago Medical Journal and Examiner* for Dec. 1882, mentions the efforts that he made to find the bacillus; but, not succeeding at first, he took it for granted that it was not to be seen at all, and that what European investigators had found were fat crystals. Formad is as clever a microscopist as Schmidt. In the *Philadelphia Medical Times* for Nov. 18, 1882, he questions the distinction in regard to staining between the bacillus of tubercle and other bacilli, suggesting the belief that he himself never managed to see the bacilli of tubercle. He has succeeded in seeing rabbits die of tubercle after the introduction of pieces of metal, glass, &c., into their bodies; and he does not seem to be aware of the investigations of Cohnheim and Salomonsen, showing that tuberculosis of the iris can be produced by nothing but inoculation with tuberculous material. He has been trying for four years to find a distinction between scrofulous and non-scrofulous tissues, and, thinking that he has now found it in the greater narrowness of the lymph-spaces in scrofulous connective tissue, he considers the doctrine of bacilli to be superfluous. Sternberg (*Medical News*, No. 41) could not find the bacilli either, and therefore considered it necessary to deny their existence.

German literature produces similar specimens. Beneke (*Die Erste Ueberwinterung auf Norderney*, Norden, 1882) denies the existence of tubercle-bacilli, because he has found what he considers to be similar bodies in an alcoholic ethereal extract of healthy blood. Koch calls to mind that in 1876 the bacilli of malignant pustule were also considered to be inorganic crystalline bodies.

Crämer (*Sitzungsberichte der Physikalisch-Medicinischen Societät zu Erlangen*, Dec. 1882) reported that he had found bacilli in the feces of twenty healthy individuals. This was soon contradicted by communications by Menche from the medical clinic at Bonn, and must be looked upon as an

error. Even if bacilli were found which stained in the same way as tubercle-bacilli, it would not be enough to prove their identity, for bacilli in lepra stain as in tubercle, but do not give the disease to animals by inoculation.

Balogh stated, in the *Wiener Med. Wochens.*, No. 1, 1883, that he had found bacilli in slime, but Koch has repeatedly invested the slime of the Berlin sewers with a negative result.

Schottelius (*Virchow's Arch. für Path. Anat.*, Band xci. Heft 1) mentions that the inhalation of non-tubercular substances causes nodes (Knötchen) in the lungs of dogs, which are anatomically the same as those of tubercle. In the same way, a smallpox pustule ought to be regarded as identical with one produced by antimony, although the one contains an infectious material and the other does not. All such nodes in the lungs Koch would test by inoculation, and he thinks it would be best to give the name of tuberculosis to the majority, which are infectious, and to find another name for the minority which are not. Another of the objections of Schottelius is, that tubercle is various in its manifestations in different animals; but it is not more so than malignant pustule is, and, if he consider the bacilli to be an accidental coincidence in tubercle, he must, to be consistent, consider as well not only the bacilli of anthrax, but also the trichina and the ascaris to be accidents, and not essentials, of their respective diseases. Schottelius, however, is chiefly concerned in disproving the connection between "Perlsucht" in animals and human tuberculosis; and he gives as a reason, that the flesh of animals so diseased has been eaten without injury. But Koch considers it doubtful if flesh containing tubercle has really been eaten, and an occasional case in which it had been done with impunity would not disprove the danger in general.

Dettweiler (*Berliner Klin. Wochens.*, 1883, Nos. 7 and 8) considers bacilli as an accidental accompaniment, and not as a cause of phthisis, although he found them, almost without exception, in eighty-seven phthisical patients. If he considers that all the bacilli are accidental coincidences, how is it that one disease invariably happens to be accompanied by small bacilli, another by large, and a third by micrococci?

Spina's *Studien über Tuberkulosis*, Wien, 1883, is the first work that criticises Koch's investigations in their entirety, but his researches are not made in at all the same way as Koch's. He worked with water-immersion lenses instead of oil, and did not use Abbé's illuminating apparatus; he stained his preparations in an insufficient manner, and examined his aniline preparations in glycerine instead of Canada balsam. With these and other errors in procedure, it is not surprising that his results were different from Koch's. In inoculation he was not more fortunate. He treated his blood-serum with insufficient care, and allowed it to dry up; and after the inoculation he waited until his animals died, instead of killing them at the end of three or four weeks, giving them a chance of developing tubercle from the confinement alone. After pointing out the errors in his cultivation of the bacilli, Koch remarks that the only result of the book is to detract from the scientific reputation of the author and of the institution where his researches have been made, and he hopes that the next criticisms which he has to answer will be more carefully worked out.

ALICE KER, M.D.

ARTICLE 787.

KÜSTNER ON TRANSFUSION OF ALKALINE SOLUTION OF CHLORIDE OF SODIUM IN ANÆMIA.

In the *Deutsche Medicinische Wochenschrift*, March 21, Prof. Otto Küstner publishes an article on this subject. The experiments of Golz, twenty years ago, on the mechanism of death by hæmorrhage, remained for a long time without any influence on therapeutics. Golz, and later Kronecker and Sander, pointed out that death does not result from the small quantity of blood in the body, but from that quantity being too small to circulate through the vessels, on account of the want of tone in the circulatory system. If this tone be restored by the introduction of even an indifferent fluid, the amount of blood which is thereby set in motion is sufficient to supply the needs of the system until more is formed. Von Ott was the first to give to the world his observations on the employment of a weak solution (6 per cent.) of chloride of sodium. He showed that, after its use, the number of the red blood-corpuscles, and the amount of albumen in the blood, returned to the normal in a few weeks, and that it acted in the same way as the transfusion of serum. Since the appearance of Schwarz's work, in the summer of 1881, several cases have been published of lives having been saved through the transfusion of the alkaline salt solution; and even in cases where death followed soon, there has always been a distinct improvement immediately after the injection. Besides the author, the operation has been performed by Bischoff, Kocher, Kümmel, and Schwarz.

In the following case, transfusion certainly prolonged the patient's life for some weeks. A woman 34 years of age, always delicate, but never seriously ill, became pregnant for the second time in August 1882. On January 8, 1883, severe bleeding came on suddenly, which, after lasting through the next day, was followed, on Jan. 10, by the expulsion of a recently dead fœtus, the placenta being expelled before the child. Enormous flooding followed, unaffected by friction, irrigation, or even injection of iron into the uterus. The removal by the hand of a portion of the placenta found adherent to the posterior uterine wall resulted in the cessation of the hæmorrhage; but the patient was now in a condition of the most intense anæmia, passing from one fainting fit into another, and vomiting without cessation. At this stage, Prof. Küstner was called in, to find the patient conscious, and complaining of want of air and a feeling of wretchedness, the pulse 136, small and threadlike, the mucous membranes pale and cyanotic, the respiration 36, laboured. The uterus was well contracted, and no more blood was flowing.

Envelopment of the lower limbs in flannel bandages and subcutaneous injection of ether caused a marked improvement in the conditions, but two and a half hours afterwards the symptoms were such that transfusion was resolved on. The median basilic vein was exposed for the length of 4 centimètres (1½ inches), and the nozzle of the apparatus introduced into the central end, the peripheral side being ligatured. The patient was now so low that the whole of the operation was performed without a sign of feeling on her part; but the solution had not been flowing for more than a minute or two before she drew a deep breath, and murmured a complaint of feeling cold. When one litre had been injected, in

about ten minutes, the pulse was full and strong, the respiration quiet, and the sensorium clear. One and a half litres in all were injected, the vein ligatured, and the external wound secured by four sutures. The complaint of cold continued to be made for four or five hours; but by the end of that time the paleness of the skin had changed to a rosy hue on the face, the tongue was moist and red without any fur, and the only complaint was of hunger and weariness. On January 13, the patient having progressed very well until then, the lochia were somewhat putrid, and an attack of pelvic peritonitis came on which lasted till January 21, but from which she recovered completely, some meteorism of the abdomen alone remaining. She was also a good deal disturbed with flatulence, which, however, caused her no pain; and she had been sitting up in bed, and even occasionally in an easy chair, when on February 3 she suddenly died, with symptoms of acute peritonitis. An ulcer in the greater curvature of the stomach was the cause of death from perforation, and the meteorism and flatulence which had hastened the perforation were caused by the adhesion of one or two coils of small intestine in the pelvis, bound down by exudation. The fluid exuded into the pelvis during the preceding peritonitis was in process of being absorbed, and the genital organs were normal, the site of the placenta prævia being distinctly seen on the lower part of the uterine cavity. The brain was very anæmic. There is no doubt that the transfusion in this case saved the patient's life for a time, and would have done so altogether but for the ulcer in the stomach. Professor Küstner ends by expressing his decided preference for venous rather than arterial transfusion, in spite of Bischoff's recommendation of the arterial.

ALICE KER, M.D.

ARTICLE 788.

HILLER ON NEW MEDICINES.

In the *Deutsche Med. Wochenschr.*, Feb. 21 and 28, 1883, Dr. A. Hiller details the experience of five new medicines employed in the medical clinic of Herr Leyden in Berlin. These are: 1. Tannate of soda (natron tannicum); 2. Extract of Calabar bean; 3. Tannate of cannabin (cannabinum tannicum); 4. Acetal; and 5. Convallaria majalis.

1. *Tannate of soda* is prepared by mixing a solution of tannic acid, 5 in 170, with a concentrated solution of bicarbonate of soda to perfect saturation. The drug is better borne by the stomach than tannic acid itself, and its harsh astringent taste is easily disguised by glycerine; but Dr. Hiller has not found it so beneficial in the treatment of albuminuria as was expected from the experiments of Ribbert on animals. Its action is slight when any organic defect in the kidney is present, and it seems to be most useful in transitory attacks of albuminuria. The solution proposed by Lewin, and quoted above, has only a weak astringent action on the tongue and mucous membrane, and does not precipitate albumen in solution, from which Dr. Hiller concludes that its styptic effect will not be great.

2. *Extract of Calabar bean* has been recommended by Subbotin (*Arch. für Klin. Med.*) and others as a powerful tonic for the muscular coat of the intestines. It has been employed in Leyden's clinic in the formula of 1 decigramme (1½ grains) of the extract to 30 grammes (1 ounce) of glycerine, of

which ten drops were given three or four times a day, and it has been found to be an energetic tonic in cases of atony of the bowels. Its effects, however, are not lasting, but pass off after the drug has been discontinued for two or three days; and in one case, after it had been employed for two days, it caused most alarming attacks of palpitation, with irregularity of the pulse, precordial anxiety, and a feeling of impending dissolution. Dr. Hiller recommends that it should be given as an intestinal tonic with great caution for only two, or at the most three, consecutive days, and with careful observation of the pupil, whose contraction gives the first sign of the commencement of tonic action. He suggests as the result of his experiments with the drug on animals, where he found that it restricted the peristaltic action of the intestines, that it might be employed with advantage in Asiatic cholera.

3. *Tannate of cannabin*, recommended by Frommiller as a safe hypnotic, free from unsatisfactory after-effects, has been found by Dr. Hiller to be most useful in cases of slight sleeplessness, when unaccompanied by pain or psychical irritation. An evening dose of half a gramme ($7\frac{1}{2}$ grains) was sufficient to produce a night's sleep, and no disturbance of digestion, circulation, or respiration has been found to result from its use. It was prescribed in powder in combination with sugar.

4. *Acetal*, or, more properly, diethylacetal = $\text{CH}_3\text{CH}(\text{C}_2\text{H}_5\text{O})_2$, was highly spoken of by Von Mering (*Deutsche Med. Wochenschr.*, 1882, No. 43) as a specially safe anæsthetic, acting first upon the cerebrum, then on the spinal cord, and lastly on the medulla, so that the effect on the heart would not begin until both consciousness and reflex action were abolished. As a hypnotic, Dr. Hiller has found it impracticable on account of its burning taste, and the enormous doses in which it must be taken in order to induce sleep, it being six times weaker than chloral. No unfavourable effects on pulse or respiration were found to follow its employment, but, on the other hand, the patients complained in the morning of stupefaction and weight in the head, and in one case of faintness and nausea.

5. *Convallaria majalis*, the lily of the valley, which has been used as a diuretic in Russia and France, has completely failed in the hands of Dr. Hiller in all the preparations which he has employed. He thinks his failure may be owing to some therapeutic difference in the plants belonging to different countries, and he proposes to make experiments with the Russian and French varieties, if he fail with the active principles of the German plants.

In a discussion on the paper in the Verein für innere Medicin on Feb. 5, Herr Lewin supported the claims of tannate of soda against Herr Hiller's declaration that it was weaker than tannic acid. He showed that, as tannic acid is changed in the body into tannate of soda or potash, it must have the same result to give the salt at first. He stated, in answer to Herr Steinauer, that tannin did lessen the albuminuria in Bright's disease, and that the soda salt could be borne for a longer time than the acid itself.

In the discussion on the extract of Calabar bean, it was brought out that it acts only on the unstriated muscular fibres, and has no action on the œsophagus or stomach, but chiefly on the small intestine.

The tannate of cannabin was considered not to be

so useful as was at first believed, and large doses were by all considered necessary to produce sleep, which, when produced, was not always very satisfactory.

Acetal was condemned as not suitable for use as a hypnotic, and Herr Lublinsky said he had only once succeeded in obtaining a good result from the use of convallaria majalis, while Professor Jacobson had had no success with a specimen sent direct from Paris.

Alice Ker, M.D.

ARTICLE 789.

PATELLA ON SOME ANTIPYRETIC AGENTS.

DR. VINCENZO PATELLA writes as follows in the *Gazz. Med. Ital. Prov. Venete*, April 25 and May 5, 1883.

The hopes conceived of the specific action of this or that remedy in contagious fevers vanish with clinical experience. Quinine in malarial fevers still stands alone as an example of this so-called specific action. Salicylic acid was at first thought to be specific in typhoid fever, but, as Lancereaux says, however useful it undoubtedly is, it does not enable us to shorten the normal course of the disease by a single day; so with carbolic acid, thymol, and all the other agents used, not to combat fever as fever, but to attack the cause. It was the idea of their antiseptic property which led to the use of these remedies in fevers, and nothing could appear more rational than to attack in the blood the germs of the various infections. None, however, appear to influence their course or duration, or to have the least specific action. This ought not to surprise us; attacking the poison-germs in the body after they have invaded the tissues, the plasma, and blood-corpuscles, is a very different thing from destroying by direct contact the various agents of ordinary fermentation. With carbolic acid, for example, it is found to require a solution of at least one per cent. to arrest the movements of vibrios in the blood. This is equivalent to giving a dose of 40 to 45 grammes (3x to 3xij) of phenol. And though phenol and salicylic acid destroy the germs of putrefaction, we have no proof of their effect on the so-called ferments of typhoid, scarlatina, and diphtheria. They may be without influence on these, as they are in the case of many anaerobic ferments. Administered in the various infective fevers, they exert a distinct antipyretic action. Can this be said to depend solely on their antizymotic property? Many substances—veratrin, digitalis, &c.—are certainly antipyretic without being antiseptic. The antipyretic action of antiseptics is equally exerted in fever of non-infective character—the fever of inflammation—as in simple acute pleurisy and peritonitis not of surgical origin. In spite of the mechanism of their antipyretic action being unknown, this action renders them very valuable remedies, enabling us to combat successfully the grave dangers of hyperpyrexia, cardiac paralysis, &c. In Germany, the antithermic treatment (the direct abstraction of heat by baths, &c.) has prevailed; but in the recent discussion on typhoid fever in Paris antipyretics seemed more in favour, associated or not as occasion seemed to require with antithermics. These agents are very numerous, and their value differs, not altogether as to the intensity of the remission they cause, but rather as to the way they are tolerated by the system. A perfect antipyretic should exert a

prompt, efficacious, and lasting effect, unaccompanied by local or general disturbance.

Dr. Patella compares shortly the different agents in use.

Quinine, the most used and trusted, must be given in large doses, 2 or 3 grammes or more (30 to 45 grains). The greatest reduction of temperature is after six or eight hours. The disadvantages are the large dose and slow action; it is often badly borne; it may affect the heart, and be the cause of sudden death in typhoid fever (Hardy).

Veratrin, an antipyretic and antiphlogistic, often succeeds where quinine fails, but frequently at the price of serious collapse following the sickness which the remedy causes even in small doses.

Of *Digitalis*, the infusion is preferable (Gubler) in inflammatory fevers (Traube), and typhoid fever (Wunderlich). It is often dangerous, especially with the quick empty pulse of cardiac weakness.

Salicin acts quickly, and is well borne. The dose is 3 to 5 grammes. Senator has given with advantage as much as 10 or 12 grammes in twenty-four hours.

Carbolic Acid, in sufficient dose, causes gastric catarrh. It is given by the rectum, 1 or 2 grammes in 200 of water in two or three enemas in the twenty-four hours. Dujardin-Beaumetz says it is very efficacious in typhoid fever, but always dangerous. Convalescence is prolonged, and there are often bronchopulmonary complications. Its antipyretic action is well marked, but always dangerous.

Salicylic Acid is preferable to quinine in infectious and inflammatory fever. Its effect is prompt and lasting, but it is often badly tolerated, causing vomiting, pyrosis, head-symptoms, and collapse.

Thymol is good, but may cause pyrosis and collapse, which is not dangerous, and may be avoided by divided doses, two or three grammes in two or three hours. It does not depress the heart as much as salicylic acid. The temperature is markedly lowered, the respiration and pulse diminished.

Resorcin is well borne by the stomach; it may cause giddiness, redness of the face, quickened respiration, quick and irregular pulse. It is less active in fever not having tendency to remission, but even in pneumonia it notably reduces the temperature. The dose is 1·5 to 2 grammes in 130 of water in two hours. It is antipyretic in all pyrexias, even in the obstinate pyrexia of some cases of phthisis. Better than salicylic acid, it does not seem to be cumulative, and may be given in large doses several days in succession.

Cairina and *Cairolina* are chinoline derivations (Fischer and Rinige, of Munich). Hydrochlorate of *cairina* is a grey powder, soluble in water, with aromatic taste. The dose is 30 to 50 centigrammes every hour or hour and a half. Its antipyretic action is displayed in all febrile diseases. Filehne used it with great success in rheumatic fever, septicaemia, typhoid fever, phthisis, and pneumonia. Pneumonia, which more than any other disease resists antipyretics, may run its whole course without elevation of temperature under the influence of *cairina*, as happened to a patient of Filehne's. The fall of temperature is rapid and great, and attended by sweating; the temperature soon rises again, with shivers; and to prevent this it is necessary to continue the drug in small doses (25 centigrammes) every three-quarters of an hour until the original temperature is reached. Filehne and Hallopeau consider these by far the best of all antipyretics.

In these agents we have valuable remedies for the symptomatic treatment of fever, and which, alone or in combination with antithermic treatment, enable us to combat the dangers of hyperpyrexia.

G. D'ARCY ADAMS, M.D.

ARTICLE 790.

HOROVITZ ON THE TREATMENT OF SEVERE CATARRHAL CYSTITIS BY CYSTOTOMY.

DR. HOROVITZ, of Vienna (*Wiener Med. Wochens.*, Nos. 13 and 14), remarks on the changes that have taken place in respect to operations on the bladder. At one time lithotomy was the only operation for the removal of stone or foreign bodies from the bladder. Lithotripsy has to a great extent replaced it in these cases, and cystotomy is now widening the range of its applicability. He then describes cases of cystitis, which resist all treatment, whether medicinal or instrumental, and which, unless boldly taken in hand, lead on to fatal nephritis and pyelitis.

The urine in these cases varies in colour, from light yellow to dark red-brown, is alkaline in reaction, with ammoniacal or foetid smell, of high specific gravity, with thick slimy deposit of mucus, pus, blood-corpuscles, epithelial cells, with crystals of triple phosphates and urate of ammonia, and large quantities of bacteria. In cases in which the kidneys are already involved, casts are to be found. The patient suffers extremely from great pain over the bladder and along the penis, from constant straining and consequent loss of sleep, and all catheterisation is attended with great agony. His health is completely destroyed, by loss of sleep and appetite, by constant drain of albumen, and the accompanying febrility. The author maintains that a bladder in this condition (cystitis of the third degree, according to Dittel), resembles and must be treated like an abscess cavity, which discharges by a long and tortuous sinus, and is constantly bathed by an irritating and decomposed secretion. The urethra, even if healthy, is insufficient for the discharge of the thickened secretion, and this imperfect drainage necessarily aggravates the diseased walls of the bladder. There is also generally a loss of contractile power of the bladder, and not unfrequently a sacculated condition of that viscus, both of which also tend to retention of the secretion. In such cases, the only operation likely to be of any benefit is perineal section with free drainage.

In 1803 Bouchardat, and in 1855 Fergusson, performed cystotomy for relief of cystitis, but these cases were not published.

In 1867 Parker, of America, published an account of a case which he treated in this way in 1851.

The following is a list of all the cases published up to now:—

		Cured.	Benefited.	Uncured.	Died.
Weir	collected 47 cases	23	7	4	13
Post	published 1 "	1	—	—	—
Brass	" 1 "	—	—	—	1
Verneuil	" 2 "	1	—	—	1
Harrison	" 2 "	1	—	—	—
Thompson	" 2 "	2	—	—	—
Dittel	" 3 "	2	—	—	1
Total	. 58	30	7	4	16

Thus of 58 cases, 30, or rather more than 50 per cent., were cured, while 16, or 30 per cent., died; of

these, however, 15 suffered from deep-seated kidney mischief, which in all probability existed before the operation—that is to say, the operation was performed too late. The author insists on the necessity of careful examination of the kidneys by palpation, percussion, and analysis of the urine before deciding on an operation.

In 34 cases, lateral section was performed; in 5, bilateral section; in 10, median section; in 5, urethrotomy; in 2, prerectal section. Sir H. Thompson and Professor von Dittel both consider that external urethrotomy affords quite sufficient drainage, and is less liable to secondary hæmorrhage. The author considers that the condition termed by the English 'irritable bladder' is not a fit case for the operation, as the symptoms depend, not on an abnormal condition of the bladder, but on some disease of the kidney or urethra.

He finally describes five cases of Dittel's, of which two recovered, and three died.

HERBERT MILTON.

ARTICLE 791.

FÉRÉ ON A CASE OF OPHTHALMIC MIGRAINE CONSTANTLY RECURRING AND FOLLOWED BY DEATH.

IN the *Revue de Méd.* for March M. Féré relates the case of a barrister who was afflicted with ophthalmic migraine dating back to adolescence, and which was accompanied in the early stages by slight troubles of speech. At the age of fifty-three he had repeated attacks, followed by permanent aphasia and right brachial and facial hemiplegia; then convulsions at first localised, subsequently becoming general; and ultimately an apoplectic attack ending in death.

His early manifestations began with troubles of sight and tremulous zigzags, luminous or obscure, lasting at times a whole day. Sometimes there was an obscuration of sight, either as right hemianopsia or else obscuring the whole visual field. Retinal images at times remained very persistent. Later he had headache, localised at first on the left frontal eminence, gradually extending all over the head, but always predominating at that point, and ending in copious bilious vomiting. These attacks were induced by the slightest cause, and invariably followed travelling.

This condition of affairs appears to have continued until October 1882, when he was suddenly seized with partial paralysis of the *right* hand, accompanied by slight embarrassment of speech. These symptoms not improving, he went, in Jan. 1883, to Paris to see M. Charcot; and when there the zigzags returned, and were shortly followed by increased trouble of speech, together with stiffness and pricking in the *left* side of the mouth, and slightly at the tips of the fingers of the *left* hand. This was followed by a suffocative attack, with cyanosis, apparent immobility of the larynx and thorax, superficial and rapid respiration, and difficulty of deglutition. The attack passed off, leaving numbness of the left hand and of the lips on the left side.

A few days later, a fresh attack occurred, in which the access of migraine with visual troubles was accompanied with stiffness of the left arm and side of the face, and complete loss of articulation, but without loss of consciousness. Then the hand began to twitch, and the left upper limb raised itself by

leaps, while the left side of the face began to grimace. This was followed by convulsive movements of the left lower extremity. These symptoms passed away for a short time, but on the next day he became suddenly insensible, the face and eyes twisted to the right, the displacement returning after correction; the right forearm and hand were strongly flexed, the right lower limb rigidly extended. The left cheek was relaxed; the facial deviation, due to paralysis of the right side, being nearly corrected. These effects passed off, but the patient succumbed to a further attack the same evening.

In respect to this case, M. Féré points out that, while this succession of phenomena has not hitherto been recorded in connection with ophthalmic migraine, the symptoms which terminated the case render it likely that in similar cases it has not been possible to trace the antecedents with equal success. He argues that a case of ophthalmic migraine ought always to suggest the possibility of grave lesions, which render it indispensable to endeavour to discover the cause. 'In migraine there exists a constriction, transitory at first, of the vessels under the influence of mischief in the sympathetic nervous system; little by little this constriction becomes permanent, and determines a thrombosis which causes the death of the tissues comprised in the vascular region affected.' 'In a first attack an aphasia is produced followed by a permanent affection of the speech, with partial paralysis of the face and of the hand on the right side. These troubles, coinciding with a left frontal cephalalgia, mark a lesion seated in the left cerebral hemisphere. The limitation of the paralysis, and the character of the troubles of speech and of the paralysis, which was partial and variable from moment to moment, allow us to assert the existence of a cortical lesion comprising the posterior part of the third frontal convolution and the neighbouring part of the motor tract. The simultaneous existence of sensory troubles does not contradict this idea; for the facts published by MM. Tripier and Petrina show that often enough motor paralysees of cortical origin are associated with troubles of sensibility more or less marked: aphasia is often enough found so associated, and troubles of sensibility in these cases may affect the special senses, notably vision.

'In a second series of phenomena it is the *right* side of the body which is affected: there are at first numbness and pricking in the fingers and lips, then supervene convulsions and paralysis. These troubles indicate further cerebral mischief, this time situated on the right side, but yet, in all probability, affecting the cortical matter, and in the same neighbourhood.

'In short, the repetition of a purely functional disorder through a long number of years has ended by determining a bilateral and symmetrical lesion.'

K. W. MILLICAN.

ARTICLE 792.

BUSCH ON EXTIRPATION OF THE RECTUM, WITH THE FORMATION OF A MUSCULO-CUTANEOUS FLAP.

PROF. BUSCH refers (*Berliner Klin. Wochenschr.*, April 9) to an operation described by Hüter, in the year 1872, in which the rectum was extirpated, union between the mucous membrane and the external sphincter and integuments having been secured, so that the distressing occurrence of alvine

incontinence was avoided. Only one or two instances of this operation have since been recorded, and in those cancer was the disease to be removed. It is, however, Prof. Busch remarks, in syphilitic stricture of the rectum that the operation is most eligible. This malady is one of the most painful and intractable to ordinary modes of treatment, such as dilatation by bougies or by forcible distension under chloroform, under which treatment the subsequent pain and suffering are most intense, and, when an incision is made, is not seldom attended with severe hæmorrhage and fecal infiltration of the adjacent tissues, and consequent phlegmonous inflammation. Should the patient escape these dangers, he is still exposed to a recurrence of the same morbid conditions. For these reasons Prof. Busch operates in such cases, in a manner differing in several points from Hüter's description of his mode of proceeding, and relates a case in illustration.

A woman, aged 35, who had suffered from nodes on her elbows, which had, however, disappeared under the use of iodide of potassium, began to experience severe pain in defæcation, the feces being evacuated in small quantities, and with difficulty. Examination discovered several polypoid excrescences within the anus; the mucous membrane to the extent of three centimètres was thickened and raised into ridges forming a close hard stricture, admitting only the end of a finger to the extent of about two and a half centimètres, beyond which healthy mucous membrane could be felt. After careful preparation of the patient, the operation was undertaken on Sept. 8, 1882. A transverse incision divided the *raphé* in the midst between the anus and the entrance to the vagina, and, curving on each side towards the sacrum, enclosed the anus in a semi-circular incision. By division of the muscular fibres of the constrictor vaginae and constrictor ani, the anterior surface of the rectum was reached. The septum between the anterior wall of the rectum and posterior wall of the vagina had now to be dealt with without opening into either of those cavities; the firm connective tissue could be divided only by the knife, a separation which it was difficult to effect. The posterior wall of the vagina was pressed upwards by an assistant, while Dr. Busch with his left hand pressed backwards the anterior wall of the rectum. Thus the connective tissue was put on the stretch, and the finger of the operator was made aware directly the knife came too near either wall. Moreover, the division was attended with profuse bleeding; every incision divided arteries, some of considerable size, so that altogether fifty catgut ligatures were used. The division, however, was finally effected, and above the stricture soft connective tissue could be felt around the rectum. The rectum was then divided with the scissors to the extent of half its lumen, and its edges provisionally secured to the skin by three strong silk ligatures to prevent its being drawn inwards. The division of the intestine was then completed, and the posterior surface of the stricture was reached from above. The stricture was readily detached from the loose connective tissue which filled the hollow of the sacrum, and the intestine was again divided at about the distance of two centimètres from the anus, the strictured portion, in length about five centimètres, being then shelled out. The lumen of the rectum was more than half closed by the existing sutures of the mucous membrane; the remaining portion of

the external part was followed up where it was most easily accessible from the opening of the wound (incision), whilst the contact of the mucous membrane was effected in the slowest possible manner. About twenty sutures were inserted; the perineal wound was again slightly opened; the effused blood readily escaped, and some iodoform was blown in. A drainage-tube was affixed, on both sides, to the nates, and the wound closed by silk ligatures which brought the flaps into their normal position. The anus remained somewhat open, through the division of the motor nerves. The finger inserted could feel the annular form of the sutured intestine, but not any trace of constriction.

The patient was much exhausted by the length of the operation, and suffered for some hours from vomiting. The first free fecal evacuation was passed on September 12. Some portions of feces passed behind the sutures. A few days afterwards, a feculent purulent discharge appeared at the wound, and escaped also from the vagina, in which a small perforation was discovered. The healing of the wound was retarded by diarrhœa. On January 16 of this year, the patient's condition was satisfactory. There was a slight mucous discharge from the vagina, but not of a blennorrhagic character. The wound in the vagina, and the perineal incision, had cicatrised. The sphincter ani had perfectly recovered its power. The finger passed into the rectum could detect a slight constriction, through which, however, the whole index finger could be passed without causing pain. The evacuation of even solid feces is easily effected.

Professor Busch adds the mention of another case of stricture of the rectum in which he had recourse to a similar operation, which, he adds, so far as he knows, has not been employed by any surgeon previously.

W. B. KESTEVEN, M.D.

ARTICLE 793.

PERRIER ON SCOTT'S APPARATUS FOR THE TREATMENT OF WHITE SWELLING.

DR. PERRIER (*Thèse de Paris*, 1882), writing on this subject, says that in 1828 John Scott made known for the treatment of white swelling a form of dressing by plaster, obtained by him from his father. Notwithstanding the oblivion into which this proceeding fell after the death of Scott, he seemed to have obtained very excellent results from it. In 1879 M. Suchard recalled attention to Scott's apparatus, which he presented to the Société de Chirurgie after having slightly modernised it. A committee of three surgeons was appointed to judge of the results obtained. The trials made at the Children's Hospital in M. de St. Germain's wards gave results which were the more important, as cases in which the affection was of the most unfavourable nature were purposely chosen. M. Suchard applies his apparatus in the following manner. He begins by very carefully cleansing the segment of the diseased limb by rubbing it with a sponge or coarse cloth steeped in camphorated alcohol, so as to obtain a lively redness. He afterwards covers the whole of the region with a piece of lint covered with a thick layer of ointment, composed of equal parts of camphorated unguentum hydrargyri and soap-cerate. A considerable quantity of the ointment is used for the knee; as much as 250 grammes (more than half a pound) is required. It is applied direct to the

skin, the lint being outside. This plaster is kept on the joint by means of a layer of imbricated strips of diachylon plaster, in the same way as for ulcers of the leg. Over these bands M. Suchard places valves of flexible but resistant leather spread on their inner surface with soap-cerate, and extending above and below beyond the subjacent pieces of the apparatus. A linen bandage applied outside keeps all these pieces accurately moulded over the joint and in perfect immobility. According to the degree of suppuration, the dressing is renewed every week or fortnight.

Dr. Cazin, chief physician of the hospital at Berck-sur-Mer, has, in his turn, modified the preceding apparatus. The washing and rubbing of the affected part are performed as above. The application of the mercurial ointment according to Dr. Suchard's method may be replaced by a copious application of vaseline spread on a layer of carded cotton, which produces the same effect. This layer of cotton is kept in place by imbricated bands of diachylon. Over this covering a fresh layer of cotton-wadding is rolled, which again is covered by a silicated bandage. With this modification, the little patients at Berck-sur-Mer run about and play in the hospital and on the beach, which is a great advantage to them.

The dressing is renewed on an average every fortnight; but the time varies according to the nature and severity of the tumour. For the same reason, the entire duration of the treatment cannot be stated.

There is still one important detail. When the limb is removed from the apparatus, it is often the seat of intense erythema. It is then sufficient to wash the skin, to powder it, and to wrap it up in a simple linen bandage during two or three days. The dressing is again applied according to the ordinary rules. This apparatus has given most remarkable results, and deserves to be very carefully considered.

ARTICLE 794.

HUMBERT ON ULCERATION OF ARTERIES IN CONTACT WITH PUS.

M. HUMBERT, of Paris, reported to the Société de Chirurgie in October of last year two cases of ulceration of the popliteal artery occurring in the course of acute osteomyelitis of the femur. In his remarks on these two cases (*Bulletins et Mémoires de la Société de Chirurgie de Paris*, No. 9, 1883), he points out that non-traumatic perforation of arteries usually succeeds the invasion, and progressive destruction of their coats, by cancerous or syphilitic neoplasms. It is less frequently caused through denudation consequent on the application of a ligature, or on removal of contiguous and adherent tumours; or by erosion due to the contact of sharp pieces of bone, sequestra, or foreign bodies. It is exceptional to observe arterial ulceration and perforation in connection with acute or chronic suppuration. The few recorded instances of perforation under the last-named condition were collected in 1874 by M. Le Dentu. Seven other cases have since been recorded; one by Bard, of Lyons, of ulceration of the popliteal complicating suppurative disease of the knee; two by Roth, of Bale, of arterial perforation during scarlatina; one case of ulceration of the carotid following phlegmon of the neck; one of a suppurating thoracic gland opening into both the œsophagus and

the aorta; and, finally, the two cases reported by M. Humbert.

The subject of the first case was a lad, aged 13, who, in September 1879, came under the author's notice with recent osteomyelitis of the lower extremity of the right femur, attended with fever, and marked by swelling and much tenderness in the affected region. On the sixth day of treatment the patient passed suddenly into a typhoid condition, and, at the same time, the swelling in the thigh and popliteal region increased considerably. An opening made into the tumour, which was thought to be a collection of pus, gave exit only to blood, which continued to flow in a jet until this was arrested by pressure. Two days later profuse hæmorrhage occurred; and before the patient could be seen by M. Humbert, it was too late to have recourse to deligation of the artery or amputation. The limb had become much swollen and gangrenous, and the patient was in a condition of extreme prostration. Death followed in the course of a few hours. At the necropsy the periosteum of the inferior third of the femur was found to have been thickened and separated from the bone by a mixture of blood and pus. The denuded osseous surface was rough, and felt like a rasp. The periosteum of the posterior intercondyloid space had been destroyed, and here the bone was quite bare. Corresponding to this bare surface there was, on the anterior wall of the popliteal artery, a perforation about one centimètre in length, running parallel to the long axis of the vessel. The margins of this perforation were very irregular. The inner surface of the artery was smooth, and in a perfectly normal condition. The popliteal space was filled by coagulated blood, mixed with a small quantity of pus.

The second case was observed in July 1880. The patient was a male, aged 20, who came under the care of M. Humbert, with an extensive fluctuating swelling at the lower and internal part of the left thigh, which had followed a supposed attack of acute articular rheumatism. An incision made into this swelling, which was taken for an abscess, gave vent to about half a pint of blood, partly fluid, and partly coagulated. The finger, introduced through the incision, passed into a large cavity, at the bottom of which could be felt the anterior surface and the inner border of the femur everywhere covered by periosteum. The patient recovered with a stiff knee, after prolonged suppuration. No bare bone could be felt in this case, but it is thought that more advanced lesions might have been found if the posterior surfaces of the femur and tibia in the popliteal space could have been explored. It is impossible to state what was the vessel that had been opened. It must have been one of little importance, as there was no subsequent hæmorrhage, and the circulation in the limb was not interfered with.

Cases of arterial ulceration following suppuration in the same region are so rare, and seem to occur under such varied conditions, that their pathogenic interpretation is rendered extremely difficult. The arterial lesion cannot be attributed to the action of pus. In these two cases, though suppuration had preceded the perforation, the quantity of pus that had been formed was very small. Moreover, it is well known that pus respects vessels, even in collections of long standing. With regard to the part played by the perforated artery itself, there may be favourable anatomical conditions, such as were pointed out by M. le Dentu in the case of the internal carotid, and such as may be attributed to the popliteal, in the close

relation of this vessel to the femur and the traction to which it is exposed during movements of the leg. Then there may be lesions of the vascular walls, such as granulo-fatty degeneration or atheroma, causing friability or ulceration of the coats, and diminution of their physiological resistance to the pressure of the blood-stream. Together with these intrinsic and rare causes, another element that has to be considered is the action of the neighbouring parts. This action is purely mechanical. Thus the rubbing of a sequestrum, the contact of a denuded osseous surface, may at length denude and even erode more or less deeply the arterial walls. Finally, there is a third variety of conditions favourable to the production of arterial ulceration. Those which depend on the general condition of the patient, M. Humbert states, are probably the most important. The study of that form of secondary hæmorrhage, in which a vessel ulcerates and opens above a ligature, demonstrates that denudation of the vessel and surrounding suppuration are not always solely responsible, but that with those local causes there is associated a general influence, the action of which cannot be questioned. In the majority of instances of spontaneous perforation, the artery is opened at a weak point, but the ulcerative action is powerfully aided by a remote cause. In chronic affections we have general failure of nutrition, exhaustion, hectic, and the visceral lesions of frequent occurrence after prolonged suppuration; and in acute affections some serious general condition of septic poisoning. In many cases the arterial perforation occurred during the course of scarlatina, and, like diffused phlegmon and acute osteomyelitis, may be regarded as a septic affection.

In conclusion, M. Humbert states that, when we seek to explain these exceptional and obscure cases of spontaneous arterial perforation, we find it difficult to assign a single cause; and assume that the interpretation of this lesion is to be rendered in the readiest and most rational way, by invoking the concurrence of many both contemporaneous and successive causes, among which the general condition of the patient ought always to be taken into serious consideration.

W. JOHNSON SMITH.

ARTICLE 795.

HAYEM AND GIRAudeau ON THE LESIONS OF THE MEDULLA OBLONGATA CONSEQUENT ON CHRONIC MENINGITIS.

IN a paper by MM. Hayem and Giraudeau in the *Revue de Médecine* for March, after referring to the three forms of chronic meningitis, viz., that connected with chronic diffuse encephalitis, that consequent upon acute meningitis, and that which is chronic from the first, occurring principally in syphilitic, tuberculous, and alcoholic subjects, the authors state that the latter form may remain latent through life, may give rise to obscure symptoms as headache, vertigo, hebetude, loss of consciousness, &c., or may in addition originate paralysis of one or more cranial nerves, the cause of which is due to their compression by inflammatory exudation. When the exudation presently disappears, the paralysis is temporary; but, when it remains, atrophy ensues, the paralysis being then permanent. Two cases of the latter class, occurring at St. Antoine, have given the authors an opportunity of studying the lesions of the medulla.

The first case was that of a woman who died in hospital of puerperal peritonitis. She had, however, besides, a complete left facial hemiplegia dating from infancy, and presenting all the ordinary signs—drooping of the mouth, disappearance of the superficial markings, puffing of the affected cheek on respiration, and internal strabismus due to paralysis of the left sixth nerve. The chief cranial lesions were thickening of the cranial bones and disappearance of the diploë, adhesion of the dura mater to the bone, the part lining the vault being covered by an osseous layer, disappearing towards the base, but returning at the orbital fossæ and the petrous portion of the temporal bone. The sixth and seventh nerves were atrophied on the left side, as were also their roots, both being pearly and resistant like fibrous tissue. The process of dura mater surrounding the facial nerve at its entry into the internal auditory meatus was also covered by an osseous layer, compressing the nerve and causing its atrophy; there was the same condition with the sixth nerve as it enters the cavernous sinus. The medulla and pons Varolii were atrophied on their left halves; and this atrophy was found, on microscopic examination, to be due to atrophy of the roots of the left sixth and seventh nerves (especially the former), which were only represented by greenish yellow streaks.

After remarking upon the exceptional character of the 'external osseous pachymeningitis,' the internal form being that ordinarily found, the authors relate the second case, in which the patient also died of peritonitis. In this case, the subject of alcoholism, there was marked atrophy of the right half of the tongue, the mucous membrane hanging in loose folds. There was no facial paralysis in this case, and the sensibility of the affected side was intact; but no lateral movements could be effected on that side, and there was marked deviation on protrusion. The lesions here consisted of highly vascular new membranes on the inner surface of the dura mater, adhesion, thickening, and great vascularity of the arachnoid and pia mater on the convexity of the brain, disappearing towards the base, but reappearing at the pons and medulla.

The medulla was encased in a fibrous sheath, which was prolonged upon the right hypoglossal as far as the anterior condyloid foramen. This nerve was only of one-third the size of the left, and, as well as its roots, was resisting and pearly white. The muscles of the tongue on the affected side had a yellow tinge, and the line of demarcation between the sound and affected halves was well marked on transverse section. The medulla oblongata, on transverse section through the olivary processes, was of smaller calibre on the right than on the left side, especially in the plane of the fourth ventricle. The roots of the right hypoglossal nerve were scarcely visible, and its nucleus was represented by a few small deformed nerve-cells. The authors point out that the lesions of the medulla consisted in an atrophy of the half corresponding with the atrophied nerves, and more marked in the neighbourhood of the fourth ventricle than at the level of the anterior pyramids. This was due to thinning of the fibres of origin of the compressed nerves, and a diminution of the number of cells in their nuclei. Those which had escaped destruction were small, and choked by the bundles of connective tissue which replaced their nuclei of origin. They compare this lesion with that found in the spinal cord when a limb has been

amputated, or in the cord of animals whose sciatic nerve has been resected. The essential difference between the lesions described and those of primary bulbar paralyse, consists in the facts that in the latter the affection commences in the nuclei of origin of the medullary nerves, progresses from below upwards, and recoils secondarily on the nerves so as to cause atrophy; and later on, upon the muscles, ultimately originating fatty infiltration, as Duchenne asserts; while in the former it begins by compression of the nerve, proceeds to the medulla, and there localises itself at the level of the nuclear origin of the nerve, and on the other hand in the muscles dependent thereon.

The practical point is this, that, excepting nerves of vital importance, as the pneumogastric, nervous atrophy of mechanical origin entails nothing more than paralysis of some muscular groups without serious disturbance of the general health.

K. W. MILLICAN.

ARTICLE 796.

LOEWENBERG ON DEVIATIONS OF THE NASAL SEPTUM, ESPECIALLY IN REGARD TO THE DIFFICULTIES WHICH THEY OCCASION IN CATHETERISATION OF THE EUSTACHIAN TUBE.

THIS important subject has been recently studied by Dr. B. Loewenberg, and the results of his researches are given in the *Archives of Otolaryngology*, Vol. xii., No. 1, March 1883. In investigating the nature and seat of the nasal obstruction in cases where difficulty is experienced in passing the Eustachian catheter, the author found that this was seated in the anterior and lower part of the nasal fossa, and was *alone* due to protuberances or spurs on the septum, and not, as might *à priori* be supposed, to swellings on the turbinated bones or to mucous polypi. This led him to make extensive anatomico-pathological researches on the deviations of the nasal septum, the results of which are given at length in this paper. In only one case out of seven, did the author find a septum absolutely straight in all its parts. He divides the deviations as follows; 1, horizontal deviations—*a*, superior, and *b*, inferior; and 2, vertical deviations.

The superior horizontal deviation affects the upper part of the septum, and especially the perpendicular plate of the ethmoid bone. Its convexity is oftener towards the right than towards the left. The inferior horizontal deviation occurs at the junction of the osseous with the cartilaginous septum, or, more precisely, 'at the junction of the inferior posterior border of the cartilage of the septum, posteriorly, with the anterior border of the vomer, and anteriorly with the ridge that surmounts the line of junction of the palatine apophyses of the superior maxillaries.' This deviation proceeds from the fact that the bony part on the one hand and the cartilaginous part on the other are not in the same vertical plane, but join under a dihedral angle projecting toward one side. Its convexity is more common to the left than to the right. Commencing in front as a protuberance or 'spur,' this deviation is often seen running somewhat upwards as it is traced backwards—following, in fact, the osseo-cartilaginous suture. The inferior deviation usually forms the reverse of the superior: sometimes, however, there is a kind of torsion of the septum from top to bottom.

The vertical deviations are folds which extend from

top to bottom along the septum narium in its front part, and consequently pertain especially to the cartilage of the septum. They present a convexity toward one side and concavity toward the other, and are often due to traumatic causes.

The author considers the part which deviations of the septum play in the treatment of, *a*, simple chronic coryza; *b*, mucous polypi of the nasal fossæ; and, *c*, epistaxis; also *d*, in the use of the nasal douche; and, *e*, in catheterisation of the Eustachian tube. He is of opinion that, speaking generally, the importance of deviations of the septum has been overrated as regards the injurious influence which they exercise on the functions of the nasal fossæ, whereas enough consideration is not given to the impediments they often occasion in the diagnosis and treatment of affections of these cavities. He calls special attention to the danger of injecting liquid into one nostril, if the opposite one be much narrowed by deflection of the septum. He prefers the use of a syringe to that of a siphon for the nasal douche, and in cases of considerable deviation injects only by the narrowed side.

The impediments to the passage of the catheter through the nostril are, as mentioned above, usually the protuberances on the septum, and sometimes the vertical deviations of that bone. In order to pass these with as little discomfort as possible to the patient, the author employs catheterisation combined with anterior rhinoscopy. For this purpose he recommends a funnel-shaped metal speculum, with a slit down one side sufficiently wide to allow the passage of a catheter. If, on inspection of the nostril, a protuberance be seen on the septum, the speculum is kept in position with the slit downwards, and, the field being illuminated by the head-reflector, the catheter, guided by sight, is carefully passed along the floor of the nose, it being necessary to turn the beak of the instrument outwards until the protuberance is passed. When this is accomplished, the speculum is turned round, so that the slit becomes uppermost, and is allowed to drop gently off. The author alleges that by this method he has been able to catheterise successfully and without suffering to the patient, under circumstances where the deviation of the septum made the operation impossible, or, at any rate, extremely painful by other methods. Inspection before catheterisation also often shows that in a given case an ordinary catheter would not have room to pass, and that the use of an extra thin one is necessary. The author prefers these of a particular pattern, *i.e.* with a beak of only $7\frac{1}{2}$ mm. in length, and bent at an exact right angle to the stem. Finally, he insists on the importance of examination of the anterior nares in aural affections, and lays down as a principle the necessity of exploring the nasal fossæ of every person requiring our attention for an affection of the ear. Some woodcuts illustrating the author's speculum and sections of the cartilaginous part of the nose accompany the paper. [The author speaks of the movements of deglutition being seen in cases of abnormal size of the nasal fossæ (ozæna). In our experience, an abnormal size of the nasal fossæ is by no means necessary for this phenomenon to be observed, for, with a good light (such as reflected sunlight or a strong artificial light) it may be seen in ordinary cases, and forms, as we have pointed out (the *Lancet*, Jan. 27, 1883), a good test of the permeability of the lower part of the nasal cavity.—*Rep.*]

E. CRESSWELL BABER, M.B.

ARTICLE 797.

JÜRGENSEN ON THE TREATMENT OF
CROUPOUS PNEUMONIA.

IN a dissertation on the treatment of croupous pneumonia (*Wiener Med. Blätter*, Feb. 22 and March 11) Dr. Jürgensen speaks first of the treatment of the high temperature. He considers cold baths to be a necessity when the temperature exceeds 41° C. (105.8° F.), unless the heart should be very weak, when they may induce collapse. Even if the temperature be under 40° C. (104° F.) they should be employed, if cerebral or cardiac symptoms be present. Baths, or some other antipyretic treatment, may be advantageously employed as a prophylactic in lighter cases. He suggests that cold applied to the body may limit the development of the micro-organisms, but he acknowledges that the course of pneumonia is not always checked by the most energetic withdrawal of warmth. The cold pack is recommended as an adjunct to baths in severe cases of pneumonia, and as a substitute for them in lighter cases.

Antipyretic drugs may be supposed to act directly on the micro-organisms or on their seat, rendering their further development impossible. No specific for pneumonia has yet been found. Iodine, recommended by Schwarz, has not been tried in a sufficient number of cases to prove its efficiency. Salicylic acid is not suitable for use in pneumonia, as it lowers the temperature too quickly and too much. Quinine, on the other hand, is very suitable; it lowers the temperature sufficiently and permanently, and may be employed in large doses, as the short duration of the illness prevents any fear of derangement of the digestion. It should not, however, be employed for a great length of time to the exclusion of baths.

Wine is demanded in pneumonia, and children may take from half a litre to a litre of light red Bordeaux, adults double that amount. Fever patients can take with impunity an amount which would intoxicate a healthy individual. The wine contributes a certain amount of fluid, which is much needed by the tissues; and the alcohol, while not increasing the bodily warmth, contributes an elasticity without the necessity on the part of the body to assimilate food. The objection that the use of wine from the first will so accustom the patient to it that it will not be useful as a stimulant, is met by the statement that such an administration provides against exhaustion and so obviates the necessity for stimulants, which, if they should be wanted, may be found in the strong wines, champagne, and brandy, or in the subcutaneous injection of camphor or ether. There is no difficulty in discontinuing the wine when it is no longer needed, but weakness of the heart may necessitate its continuance, or even increase, for a few days after defervescence.

Sufficient nourishment is very necessary, and Dr. Jürgensen has found that fever patients treated by baths can take plenty of nitrogenous food. Milk is most useful at first, and may be given up to several litres a day, one to two ounces of cognac being mixed with each litre. Raw meat minced, with bread and butter, and even more complicated dishes, are not to be forbidden. This treatment is adopted with the aim of keeping the patient alive by rendering the heart capable of performing its work.

The danger of collapse after the use of baths is not to be feared even in weak children, as the alter-

native is to abandon the child to the action of the disease if the fever continue in spite of the use of quinine. Baths may even be beneficial in weakness of the heart; for, when a relaxed state of the vessels, and of the muscles generally, widens the bed of the blood-stream, the stimulation of the bath narrows the peripheral arteries, giving greater resistance, and so enables more blood to flow along other channels. When cold baths have caused collapse, it has been from insufficient watchfulness on the part of the medical attendant, especially as regards the time of crisis, when the temperature falls of itself, and when baths in addition would do harm. The increase in the temperature of the body stimulates the heart, and when, by cold baths, this stimulant is taken away, another must be substituted for it. The crisis may come quite unexpectedly and without warning; and when quinine is employed as an antipyretic this crisis may occur during its time of action, which is from six to seven hours. In such a case baths are much safer, as their action lasts for a much shorter time. It is a good rule to employ a cardiac stimulant regularly on the day of crisis.

Digitalis can be employed in pneumonia only as a regulator of the heart's action. It is supposed to act by prolonging the diastole, and so increasing the period of rest of the heart, and enabling it to be better nourished. But in pneumonia the rapidity of the pulse is often in direct relation to the increased respiration, and to interfere with the one without affecting the other is to disturb the equilibrium between them. Only in cases of irregular and intermittent pulse is digitalin sometimes of service.

Inhalations of turpentine are useful in treatment intended for the lungs, especially in cases of foetid expectoration.

ALICE KER, M.D.

ARTICLE 798.

BEUSTER ON MASSAGE.

DR. BEUSTER, of Berlin, read a paper on this subject at a meeting of the Verein für innere Medicin in Berlin, on Jan. 8 (*Deutsche Med. Wochensh.*, March 12 and 28). It is desirable to consider the advantages of this form of treatment on nervous diseases as well as on others, in order to fix the limit of its operation. The treatment which is now being judged by the medical world is the oldest of all, and has been employed by men in every country and in every age. It was known to the Asclepiades, to Hippocrates and Galen, and the Greeks practised it in the fourth century B.C. In Rome, in the time of Nero and Trajan, massage formed part of the programme carried out in the tepidarium of the public baths. The Brahmans in India practised it under the name of shampooing, and Alexander the Great, when he was in India, allowed those of his soldiers who had been bitten by serpents to be so treated by the priests. It was brought to Germany by the crusaders from Syria and Palestine, but it soon passed out of the physicians' hands into those of the people, and was employed merely as a pleasurable sensation. Travellers relate stories of its extension to every quarter of the globe. The natives of Nubia and Sennar employ it largely, and Professor Hartmann found its beneficial effects during an attack of fever to be so decided that he regretted having refused so long to submit to it. Dr. Emerson tells of its employment by the Sandwich islanders, under the name of Lomi-Lomi, and honoured guests are there shampooed as a special mark of regard. In some

cases, the people lay themselves on the ground and allow their children to run over their bodies by way of massage, a proceeding which is also seen in the province of Brandenburg. In Japan it has been used from the most ancient times as a refreshment after over-fatigue, as well as to cure diseases. Massage seems, however, to have been employed earliest of all by the Chinese. In the beginning of the present century a book, 'Cong-Fou,' 3,000 years old, was translated by the missionaries Hus and Amiot, in the medical part of which all the proceedings of the Swedish gymnastics are described so fully, as to render it likely that they were really taken from this work.

The following are the different movements of massage as now practised, and as the French have formulated them.

1. *Effleurage*.—*Friction douce*.—Slow, gentle strokes in a centripetal direction along the course of the veins and lymphatics, made with the palm of the hand, oiled, and with the pressure intermitting, so as to cause passive peristaltic action.

2. *Massage à friction*, in which the finger-tips of one hand, held at right angles to the axis of the limb, rub across and across in narrow ellipses, while the fingers of the other hand stroke parallel to the axis of the limb from above downwards.

3. *Kneading* (*pétrissage*), which should also be done from the periphery towards the centre, and which consists in raising up the soft parts and kneading them in a way that may be compared to squeezing a full sponge.

4. *Tapotement*, or tapping or striking, causing concussion of the affected part, which may be done with the fingers, the palm, the margin of the hand, the closed fist, a percussion-hammer, or an instrument like a drumstick, with an India-rubber head and a whalebone stem.

The French have also various other instruments, and they employ also the passive movements of flexion, abduction, adduction, rotation, &c.

The amount of power required to be executed is very variable, and it wants much practice and experience. The number of sittings may vary from two to five in the day, and their duration from three to twenty minutes, or even one or two hours. The proceeding seems to cause the operator not only fatigue, but also a nervous excitability, from the action on the nerves of the fingers and hand.

The chief point of the question is the physiological effect which it has on the human body. Professor von Mosengeil thoroughly discussed the question in the German Surgical Congress in April 1875. The centripetal stroking favours the venous and lymphatic circulation, and acts backwards even on the parts which are not touched, so that a greater quantity of blood passes through the parts, causing increased tissue-metamorphosis. It is clear that the formation of exudation will be thereby prevented, and that exudation already formed will be removed, and even more solid formations will be fattily degenerated, and so absorbed. Pathological products can be removed even from such situations as the articular cavities, as has been proved by experiment.

Another result of massage is the diminution of pain. This may be partly due to the removal of pressure from the nerves, but it is also certain that after massage the entire sensibility of the part is reduced below normal, so that there must be some action on the nerves themselves. It may be of the nature of paralysis, or of some alteration in the

equilibrium between the nervous molecules, especially after 'tapotement.' The motor nerves, with the muscular contractility and the tone of the blood-vessels, are also affected.

Every possible form of disease has been at one time or another treated by massage, but the most important results have been seen in traumatic joint-affections, such as bruises and sprains.

The most suitable nervous cases for treatment are peripheral neuralgiæ, especially those characterised by injection and a varicose condition of the vessels of the neurilenma. Sciatica has been the neuralgia which has most repaid this treatment, but in other forms also a good result has been obtained. Articular neuroses have been remarkably improved under this treatment, but it is not to be forgotten that they are by some considered to be hysterical in nature. The other neuroses which have been treated successfully by different practitioners are the minor forms of chorea, writer's cramp, hypochondria and hysteria, infantile paralysis, and hemiplegia after apoplexy. It is particularly useful in atony of the stomach and intestines, and even volvulus has been cured by its use. It has, finally, been employed for relieving the brain of blood; and in one case of a soldier, treated by Herr Gerst, convulsions arising from nephritis were cured in four sittings in one day.

Alice Ker, M.D.

ARTICLE 799.

SPINA ON THE SUPPOSED TUBERCLE-BACILLUS AND ITS RELATION TO TUBERCULOSIS.

UNDER the above title, Dr. Arnold Spina states his views with respect to the correctness of the observations made by Koch and Ehrlich, and the deductions which they have made from them (*Allgem. Wiener Med. Zeitung*, No. 20). That his interpretation of the results obtained by these observers differs widely from their own, has been already made manifest by his previous writings on the subject. In the present paper, he enters with more detail into the particular points of difference.

With respect to the relations of the bacilli to the aniline colouring matters, he points out that Koch and Ehrlich have laid it down as a principle that the bacilli of tubercle are differently acted upon by certain colouring matters, and can be thus distinguished; that they are only tinged by certain aniline dyes when in an alkaline solution, and that they are impermeable to acids and to certain brown colouring matters. These theories are not founded upon actual observation during preparation, but are deduced from the results obtained by examination of the specimens when finally prepared.

Koch's teaching being altogether dependent upon the discovery of certain blue-coloured bacteria in the sputa of phthisical persons, the exact mode of action of the colouring matter upon these bacteria ought to have been worked out step by step by means of microscopic observation. This Dr. Spina alleges that he was the first to do. He has himself seen, he says, that acid and neutral solutions permeate the most different forms of bacteria and also the bacilli; that brown colouring matters also permeate the most various forms, including Koch's bacillus; and further, that nitric acid penetrates Koch's bacillus precisely in the same way as it affects other forms of bacteria. These observations,

exactly contradicting the conclusions which Koch has drawn, seem to do away with the barrier by which he separates the bacillus of tubercle from all other micro-organisms. That the observation of the occurrence of blue-coloured bacteria in phthisical sputa is correct, Dr. Spina does not deny; but he explains the fact by pointing out that the intensity with which bacteria are coloured, and the length of time for which they retain such colour, are by no means constant. The irregular tinging of blood-cells forms an illustration of this, but it has not yet been attempted to be proved that the cells are of different variety because they acquire and retain artificial colour with different degrees of intensity. It is well known also that, of cells belonging to one and the same category, those are tinged the deepest which are the most recently developed. The thickness of the preparation and the characters of the media in which the micro-organisms are contained may also, in their turn, exercise considerable influence upon the duration of the colouring matters. Many of these factors being beyond the control of the observer, it follows that the results of the methods of staining must depend to some extent upon chance. It is not then difficult to understand how it is that such apparently contradictory results have been occasionally obtained; and the outcome of Koch's and Ehrlich's methods is, after all, only to demonstrate how many bacteria have withstood the decolorising action of the nitric acid, and not by any means to prove the existence of a distinct species of bacteria.

As confirmatory of these views of his, Dr. Spina quotes the results of the observations made by Lichtheim, Ziehl, Finkler, and others. At the request of Professor Stricker, a fresh series of experiments were also undertaken by Drs. Kaberhel and Matray. These resulted in complete confirmation of Spina's observations with respect to the permeability of the bacilli to acids as well as to alkalies, to their permeability to the brown colouring materials, and to their absolute similarity in these as in other respects to the other forms of micro-organisms discoverable in the air-passages. A list is given of cases in which bacteria were discovered by the well-known method of staining, the bacteria appearing blue upon a brown ground. In secretions from the air-passages, intestines, or vagina, in non-tuberculous cases, the bacteria appeared in a large majority of cases.

Examined by Ehrlich's method, the number was much less. The experiments, however, clearly bore out Spina's statement that forms of micro-organisms, quite distinct from Koch's bacilli, may be coloured by the same staining process; and further, that Koch's bacilli maintain the same behaviour in the presence of the staining fluids as all the other bacteria.

With respect to the constant occurrence of the bacilli in tubercular tissues, Dr. Spina is likewise combative. If it be assumed that Koch's views are in all points correct, it follows that the bacilli, as the starting-point of the tuberculous process, should be present in the youngest developing forms of tubercle.

The earliest development of miliary tubercle may be observed with the greatest minuteness in the omentum without difficulty. The bacilli have never been found (by Dr. Spina) in such cases, except where sufficient time had elapsed for the processes of decomposition to set in; and even in these latter cases the local distribution of the bacilli has not been such as to suggest any connection between

them and the tubercular process. The bacilli only appear at the edge and in the caseating tissue; in the recent non-caseous nodules which do not stand in any connection with atmospheric air, the bacilli may be altogether absent. The experiences of English observers, as Whipple, West, and others, bear this out. The bacilli have been often found wanting in the acute tubercle, although present in the vicinity of cavities or in their contents. In tubercular disease of the testis, also, the most careful search has failed to demonstrate their presence. Latterly, the bacilli have been discovered in three cases of lupus.

Thus, concludes Dr. Spina, on the one hand the tubercle-bacilli are conspicuous by their absence from places where, according to Koch's teaching, they should be; and, on the other hand, they are present in places where, from his point of view, they ought not to have access.

E. CLIFFORD BEALE, M.B.

SURGERY.

RECENT PAPERS.

800. HASSELWANDER.—A Case of Hernia Obturatoria Incarcerata: Operation: Recovery. (*Erstliches Intelligenzblatt*, March 20, 1883.)

801. BUCHANAN.—Penetrating Gun-shot Wound of the Abdomen. (*Brit. Med. Jour.*, March, p. 609.)

802. LLOYD.—Gun-shot Wound of the Abdomen. (*Brit. Med. Jour.*, March, p. 560.)

803. BAKER.—A Case of Bullet-Wound of the Tongue. (*Brit. Med. Jour.*, March, p. 457.)

804. CHARLES.—Gun-shot Wound of the Neck with Perforation of the Oesophagus. (*Brit. Med. Jour.*, March, p. 611.)

805. MASTERMAN.—Phagedænic Carbuncle. (*Brit. Med. Jour.*, March, p. 510.)

806. PYE-SMITH.—Injury to Knee-joint, with Rupture of both Crucial Ligaments. (*Brit. Med. Jour.*, March, p. 416.)

807. O'CONNOR.—A New Treatment for Fractured Clavicle. (*Brit. Med. Jour.*, March, p. 406.)

808. WALKER.—A Novel Agent in the Radical Cure of Hydrocele. (*Brit. Med. Jour.*, March, p. 511.)

809. STOKES.—Penetrating Wound of the Bladder. (*Brit. Med. Jour.*, March, p. 565.)

810. KENNEDY.—Prurigo Podicis. (*Brit. Med. Jour.*, March 1883.)

811. LUCAS.—Ozæna due to Foreign Bodies. (*Med. Times and Gazette*, March, p. 351.)

812. SAVORY.—Enlarged Prostate and Stricture. (*Lancet*, March, p. 356.)

813. DONOVAN.—Total Suppression of Urine, lasting seventy-five hours: Recovery. (*Lancet*, March, p. 402.)

814. JONES.—Separation of the Epiphysis of the Tibia during Traction in Hip-Disease. (*Lancet*, March, p. 403.)

815. BLOCK.—Suture of Wounds of the Heart. (*Lancet*, March, p. 422.)

816. BARTON.—A Case of Large Spinal Abscess filling the Abdomen and Obstructing the Vena Cava. (*Lancet*, March, p. 453.)

817. MAY.—Retraction of the Flap after Syme's Operation. (*Lancet*, March, p. 361.)

818. HENCK.—A Contribution to Tendo-plastics. (*Centralbl. für die Med. Wiss.*, Feb. 17.)

819. COZE.—Survival after Penetrating Wound of the Heart. (*Jour. de Méd. et de Chir. Prat.*, March.)

820. KORETZKY, A. G.—The Pathology and Treatment of Erysipelatous Inflammations. (*Wratsh*, 1882, No. 23, pp. 376-9; No. 24, pp. 392-5; and No. 25, pp. 407-10.)

821. ALPAGO-NOVELLO.—Ischuria from Hypertrophy of the Prostate. (*Gazz. Med. Ital. Prov. Venete.*, April 26.)

822. RIBUS.—Cold Phenicated Baths in Surgical Inflammations. (*El Siglo Medico*, April 15.)

823. ROSER.—Angina Ludovici. (*Deutsche Med. Wochensch.*, March 14.)

824. KUMAR.—Embolic Gangrene. (*Wiener Med. Blätter*, March 8.)

825. GUSSENBAUER.—A Pancreatic Cyst. (*Ibid.*, March 22.)

826. WOLFF.—Trophic Disturbances in Primary Affections of the Joints. (*Deutsche Med. Wochensch.*, March 14.)

827. SENATOR.—Obstruction of the Veins of the Abdomen and Lower Limbs. (*Deutsche Med. Wochensch.*, March 28.)

ART. 800. *Hasselwander on a Case of Obturator Hernia: Operation: Recovery.*—A Bavarian country-woman, aged 65, was suddenly attacked, on October 24, 1882, with colicky pains, flatulence, and constipation, complete loss of appetite, occasional vomiting, and pain in the left foot. On the third day she was brought by her husband to Hausham, where Dr. Hasselwander is established as a practitioner. She was then suffering from an aggravation of the above symptoms, with great distension of the abdomen which was almost universally tympanitic on percussion. The entire left lower extremity was numb, and an itching sensation was felt in the thigh. The patient's urine was highly albuminous. On close inspection, it was found that, although the patient was much emaciated, the depression in Scarpa's triangle, between the adductor longus and the sartorius did not exist on the left side; but, on pressure over its site, which did not present any protrusion, but was simply level with the muscular boundaries of that anatomical region, much pain was produced. On vaginal examination, fullness was detected on the left side of the pelvis. A femoral hernia was suspected, and on pressure over the tender region partial reduction was effected; flatus passed from the rectum on the next day, but the abdominal pains and the tendency to vomit did not abate. Dr. Hasselwander suspected that an incarcerated obturator hernia existed, or rather that the condition of the rupture now indicated strangulation. An operation was therefore undertaken, and it proved difficult from the very onset, being performed late in the day when twilight was creeping on. An incision, four inches in length, was made through the integuments along the line of the outer border of the adductor longus, beginning from the pubes. When that muscle was exposed, the cellular tissue was dissected from its surface, and it was drawn inwards. Some fibres of the pectineus, laid bare by this dissection, were parted by means of the fingers and a pair of forceps, and this proved an easy task, owing to the relaxed condition of the muscle. During this process the hernia was plainly felt, by the operator's fingers, under the pectineus. The aperture thus made over the hernial protrusion was then enlarged, but some of the large veins were wounded, an accident that caused most troublesome hæmorrhage during the remainder of the operation; fortunately, one external pudic artery was seen pulsating in the upper angle of the wound and kept out of danger. After much time had been spent in controlling the venous hæmorrhage, the hernial sac was found to be an oval dark purple swelling, the size of a pigeon's egg; it was very tense, yet fluctuation could be detected on palpation. Some strong adhesions were separated from its exterior by the

finger. A very blunt knife was employed to open the sac, which consisted of an outer layer of fascia and an inner coat of œdematous cellular tissue; no fluid escaped, but the gut could be felt. The opening was made wider by laceration. The intestine appeared deeply congested, very tense, and sharply constricted at the neck of the sac, where it passed out of the pelvic cavity through the obturator foramen. By means of a straight probe-pointed bistoury incisions were made on the inner and lower borders of the neck of the sac, where no artery could be felt pulsating, and the fibrous tissue round part of the foramen was thus divided. With great care the intestine was then reduced. The wound was plugged antiseptically. Flatus passed directly after the operation, and a few hours later the patient's bowels acted copiously. The wound suppurated freely, delaying convalescence; but the symptoms directly caused by the hernia never returned. The patient recovered completely in five weeks. The pain in the left lower extremity disappeared immediately after the operation, but for a few days there was loss of muscular power in the limb. This was attributed to previous stretching of the obturator nerve by the hernial protrusion. According to Schmidt's recent statistics, in Pitha and Billroth's *Handbuch*, 1882, only twenty-five cases of obturator hernia have been diagnosed during lifetime: seventeen of these underwent operation, eight were relieved by taxis, and out of the entire series only five recovered.

ALBAN DORAN.

801. *Buchanan on Penetrating Gun-shot Wound of the Abdomen.*—Dr. George Buchanan, of Glasgow, in the *Brit. Med. Jour.*, March 1883, p. 609, records the case of a man, aged 25, who received a gun-shot wound in the abdomen which penetrated the body and was removed from the muscles of the back. The patient ultimately recovered. The bullet entered about three inches and a half above the umbilicus, and an inch to the left of the middle line. There was a good deal of pain in the back opposite to the wound, but there was no evidence of anything there. Grave symptoms of collapse came on, and ether was injected subcutaneously from time to time. The next day the symptoms improved, and there was no pain or tympanites; there was, however, great pain in the back, and it was decided that the bullet had lodged there. For some days the patient gradually improved, but some ten days after the accident he became febrile, with a distinct evening rise of temperature, and at length some fullness was detected in the left lumbar region. The patient was put under chloroform, and a full incision made parallel to the spinal column, giving exit to a quantity of putrid fluid. On examination, the tip of the second transverse process was found broken, and against it the bullet was found crushed and grooved. A drainage-tube was inserted after washing out the wound with carbolic acid, but after five or six days the wound was reopened and more pus let out; for four or five weeks there was constant fever with frequent rigors, and subsequently effusion into the right knee and ankle, which passed off, and the patient left the hospital convalescent about nine weeks after the accident; Dr. Buchanan being perfectly satisfied, from all the symptoms of the case, that the bullet passed directly through the abdomen.

802. *Lloyd on Gun-shot Wound of the Abdomen.*—Mr. Lloyd, in the *Brit. Med. Jour.*, March 1883, p. 560, gives notes of a female patient, aged 19, who

had been accidentally shot in the abdomen. The bullet had entered slightly to the left of the median line, immediately above the pubes. As there was little evidence of shock, and the patient had no bad symptoms of injury to any abdominal viscus, it was decided not to operate at first; but on the third day she became much worse, with persistent vomiting and severe abdominal pains, so that an operation was performed, but the patient died very soon afterwards. At the *post mortem* examination, it was shown that the bullet had entered half an inch above the pubes and three quarters of an inch to the left of the middle line. The apex of the bladder was contused, and a free edge of a coil of small intestine had been cut through; the mesentery was also perforated. The upper part of the abdominal cavity was free from inflammation. In a few remarks, Mr. Lloyd adds that he thinks it is best to operate at once in such cases, and not to wait until inflammation sets in.

803. *Baker on a Case of Bullet-wound of the Tongue.*—Mr. Morratt Baker, in the *Brit. Med. Jour.*, March 1883, p. 457, gives the notes of a case of a boy, aged 13, who received a gun-shot wound from a revolver; the bullet pierced the right upper lip, passing right through; and the upper canine and upper lateral incisor teeth on that side were completely shot out, the canine being entire, while the crown of the incisor was broken off. No wound could be found in the hard palate, or cheeks, or floor of the mouth; but on the upper and anterior surface of the right half of the tongue was a ragged wound about the size of a large pea. The boy was put under chloroform, but no bullet could be found. On the sixth day the bullet was passed *per anum*, well coated with feces. The case is remarkable, as the revolver was fired at a distance of only three yards, and the force of the bullet was broken by the teeth; it then penetrated the tongue, and must have dropped down the gullet.

804. *Charles on a Case of Gun-shot Wound of Neck, with Perforation of Œsophagus.*—Dr. Allen Charles, in the *Brit. Med. Jour.*, March 1883, p. 611, reports a case of a lad, aged 18, who was examining a pistol loaded with two slugs, when it accidentally went off, the slugs entering his neck; and from the fact that the patient commenced spitting blood after the accident, together with difficulty in swallowing, it was evident the Œsophagus was wounded. There were many points of interest in the case, amongst which were noticed—1, the readiness with which the wound of the Œsophagus healed; 2, the comparative safety of such injuries, notwithstanding the numerous blood-vessels in the part; and 3, the possibility of subsequent stricture.

805. *Masterman on Phagedenic Carbuncle.*—Mr. G. F. Masterman in the *Brit. Med. Jour.*, March 1883, p. 510, points out that, since the time of Harvey Ludlow, two forms of carbuncle have been recognised; one in which the sloughing does not extend, or very slightly, beyond the original area of the disease; the other in which this process is accompanied by fresh peripheral mischief, the disease rapidly spreading from the spot, where it first appeared, sometimes deeply, but generally limited by the superficial fascia, and attacking preferentially the skin of the face. From recent cases which have come under Mr. Masterman's care, he considers he has found out the reason of the difference in these two forms; which is, that in the severer form he has always detected albuminuria,

whilst in the other form no albumen was detected in the urine. Although glycosuria is generally mentioned as a cause of carbuncle, it has not been noted that albuminuria was a cause of it, as far as Mr. Masterman was aware; and a point on which he lays great stress is that the old treatment by stimulants is in many cases extremely bad.

806. *Pye-Smith on Injury to the Knee-Joint with Rupture of Both Crucial Ligaments.*—Mr. R. Pye-Smith, in the *Brit. Med. Jour.*, March 1883, p. 416, relates a case, in which a cabman, aged 53, twisted his right knee in falling from his cab. There was considerable lateral mobility of the joint, and it contained fluid. Pneumonia developed, and proved fatal on the eighth day after the injury. At the *post mortem* examination, the internal lateral and crucial ligaments were found to be completely ruptured; the central part of the cartilage of the patella was crushed into fibres, so as to present a plush-like appearance. The joint contained a few small clots of blood, but there was no dislocation of the joint, nor injury to the popliteal vessels.

807. *O'Connor on New Treatment for Fractured Clavicle.*—Dr. M. R. O'Connor, in the *Brit. Med. Jour.*, March 1883, p. 406, describes a plaster-of-Paris splint which he has used for some time past in the treatment of fractured clavicle. It is made by sewing the edges of two layers of flannel together, which extend from below the spine of the scapula behind, to nearly the nipple-line in front, having a concave border behind on its inner side for the neck, and outside slightly overlapping the acromion process, thus covering the entire shoulders. The outer layer is then slit from the acromion process directly inwards, thus forming two pouches, into which plaster-of-Paris is poured; the arm is now placed in good position, and the plaster manipulated until about an inch thick all over. Four elastic strings, attached to the angles of the splint, are tied under the corresponding armpits, and the arm is bandaged across the chest. The splint does not need to be taken off until union is perfect.

808. *Walker on a Novel Agent in the Radical Cure of Hydrocele.*—Mr. J. E. W. Walker, in the *Brit. Med. Jour.*, March 1883, p. 511, writes, saying that he discovered by accident a new agent for injecting hydrocele, with a view to a radical cure. One day he proposed to inject a patient, aged 65, whose hydrocele had been tapped repeatedly for ten years. He took out a bottle from his pocket, and injected two drachms of the fluid it contained. On arriving home he found that he had injected two drachms of liquor ergotæ (Battley) instead of the same quantity of tincture of iodine. No inflammatory state followed, the patient was able to walk about the next day, and the hydrocele did not fill up again. Two cases have been tried subsequently with the same fluid, and with perfect success.

809. *Stokes on Penetrating Wound of the Bladder.*—Mr. Stokes, in the *Brit. Med. Jour.*, March 1883, p. 565, gives an interesting history of a patient who had suffered from an injury to the rectum and bladder. The handle of a long pair of forgers' tongs, over which the patient was vaulting, passed through the anus into the rectum, perforating the anterior wall of this viscus about an inch and a half from the anus; here the instrument passed into the bladder through the trigone, and emerged at the fundus opening into the peritoneal cavity. The patient died about seventy hours after the accident in great agony.

810. *Kennedy on Prurigo Podicis*.—Mr. Kennedy, in the *Brit. Med. Jour.*, March 1883, p. 649, remarks that a patient of his derived great benefit from a weak solution of sulphurous acid when suffering from prurigo podicis.

811. *Lucas on Ozæna due to Foreign Bodies*.—Mr. Clement Lucas, in the *Med. Times and Gazette*, March 1883, p. 351, gives a good article on cases of ozæna due to foreign bodies, and he starts with the axiom, 'Persistent one-sided ozæna in a healthy child is due to a foreign body in the nasal cavity.' A woodcut is given, illustrating a speculum made for Mr. Lucas by Messrs. Millikin and Down, of St. Thomas's Street, whilst for an extractor for the ear or nose the author suggests heating a large curved suture needle to redness, and then pressing it against some hard body, so as to make a delicate hook. This is so fine that it will pass by without disturbing a foreign body, but in being withdrawn will retain a firm hold upon it.

812. *Savory on Enlarged Prostate and Stricture*. Mr. Savory, in the *Lancet*, March 1883, p. 356, gives some notes on the treatment of enlarged prostate and on the treatment of stricture of the urethra. In speaking of retention from enlarged prostate, the author states that much good is often gained by retaining a catheter for some time after it has been introduced, say an hour or two, with a view of producing an effect on the prostatic portion of the urethra, and to improve the power of micturition. It is also noted that a full-sized catheter with the ordinary curve is often passed more readily than the instrument especially made for cases of this description. With reference to stricture, Mr. Savory says that a great many cases are treated by instruments which ought not to be. Such cases, where there is a slight thickening of the membrane from inflammation or congestion, would recover if left alone and rest were ordered, instead of passing instruments which irritate and worry the contraction into a permanent stricture.

813. *Donovan on Total Suppression of Urine Lasting Seventy-five Hours: Recovery*.—Mr. Donovan, in the *Lancet*, March 1882, p. 402, gives notes of a case of an engine-driver, aged 42, who sent for him on account of having suffered for twenty-four hours from retention of urine. There was nothing to account for the retention in the previous history of the patient beyond being exposed to cold, and to excess of spirituous liquor. Every method of treatment was tried, but the bladder remained perfectly empty for seventy-five hours, the patient being fairly comfortable and free from pain during the time; then two ounces of high-coloured urine were passed, and after this the flow became perfectly established. Mr. Donovan considers the case as one of those rare instances described by Sir Henry Thompson as paralysis of the kidneys, depending most likely on extreme vascular congestion of these organs, paralyzing their secreting power. [In the *Medical Digest*, section 1036:3, a number of cases are reported, some lasting 58, 43, and 25 days.—*Rep.*]

814. *Jones on Separation of Epiphysis of Tibia during Traction in Hip-Disease*.—Mr. Jones, in the *Lancet*, March 1883, p. 403, draws attention to a case first reported in the *Lancet*, Feb. 12, 1881, where the traction had separated the shaft from the epiphysis, and adds some further particulars as a sequel to his former article. Mr. Jones states that the patient is at the present time in excellent health, though backward in physical development; there is

a shortening of two inches in the diseased leg, but he is able to walk a great deal without pain or uneasiness. On measuring the legs it was found that, although there was a difference of two inches from the anterior superior iliac spine to the tip of the internal malleolus in the two legs, yet there was only a difference of half an inch in the two thighs, three-fourths of the difference being due to the tibia of the diseased leg being one inch and a half shorter than the other. This Mr. Jones considers due to the arrest of the growth of the bone, on account of being separated from its epiphysis, and suggests that all the advantages of traction might be obtained by placing the fulcrum on the femur, immediately above the condyles, instead of at the ankle.

815. *Block on Suture of Wounds of the Heart*.—In the *Lancet*, March 1883, p. 422, an article appears alluding to some experiments which have been made by M. Block, by which he endeavoured to point out that death from wounds of the heart is usually due to asphyxia from effusion of blood into the pericardium, or to loss of blood, or to damage to the motor ganglia of the heart, or to obliteration of the coronary artery. By experiments on dogs and rabbits he has shown that suture of wounds of the heart can be successfully carried out in the space of three or four minutes. In order to hinder the escape of blood during the suture, the apex of the heart was seized and pulled so strongly that the pulse and respiration ceased, so that it was possible to operate, the heart being completely at rest.

816. *Barton on a Case of Large Spinal Abscess Filling the Abdomen, Obstructing the Vena Cava*.—Dr. Barton, in the *Lancet*, March 1883, p. 453, gives the notes on a case of a boy, aged 16, who had suffered from spinal curvature for five years. The abdomen was filled on the right side, pushing the intestines *en masse* to the left; and the abscess threatened to point below the ribs in the nipple-line. Sixty-nine ounces of greenish colourless pus were drawn off by an aspirator, which became blocked by flaky pus; six days after eight ounces were drawn off, and then six ounces. On a subsequent occasion, three drachms of tincture of eucalyptus were injected, and a few days after this seventy-six ounces of creamy pus were removed, the abscess being now entirely emptied. In about three months the boy went out of hospital, cured, and gaining flesh. The points of interest in the case are, that the size of the abscess simulated ascites; it took five years to form, and caused the patient very little inconvenience; also the curious effect the eucalyptus had on the flaky pus, which could not be removed on account of its character, but became fluid after the injection of the eucalyptus.

817. *May on Retraction of the Flap after Syme's Amputation*.—Mr. Bennett May, in the *Lancet*, March 1883, p. 361, refers to Mr. Savory's Notes on Surgery in the *Lancet* of Feb. 3, on retraction of the heel-flap after Syme's amputation. Mr. May's patient returned to him eighteen months after operation, with the cicatrix receiving all the pressure, and the heel part retracted quite to the back of the leg. Division of the tendo Achillis completely liberated the flap, and enabled it to be readjusted, with great relief to the patient. RICHARD NEALE, M.D.

818. *Henck on the Plastic Surgery of Tendons*.—Henck (*Centralbl. für die Med. Wiss.*, Feb. 17) says that, for four weeks after a rupture of the tendon of the flexor longus pollicis, Czerny found the divided ends more than 2½ centimètres apart (0·78 English

inch), and it was only possible to approximate them within four-fifths of an inch of each other. A longitudinal division of each end was made, and the two portions united with catgut sutures, so that the tendon could be brought as nearly as possible to its normal position. The result was very successful. Four weeks after the operation, considerable movement of the hand had been recovered; the only difference was that the distal finger-joints of the left hand could not be quite so entirely flexed as on the right.

W. B. KESTIVEN, M.D.

819. *Coze on Survival after Penetrating Wound of Heart.*—Dr. Coze (*Four. de Méd. et de Chir. Prat.*, March 1883) reports a case of gun-shot wound of the heart penetrating the left ventricle, in which the patient survived four hours and a half.

ROBERT SAUNDREY, M.D.

820. *Koretzky on the Pathology and Treatment of Erysipelatous Inflammations.*—Dr. A. G. Koretzky (*Vratch.*, 1882, Nos. 23, 24, and 25) describes how he has succeeded in almost completely expelling endemic erysipelas from the Kremenchtug Zemsky Hospital, where he has held the office of senior physician and surgeon. Before his time, and when he first came into office, erysipelas was a daily occurrence, and a common complication of wounds and ulcers. Under his administration only three cases of erysipelas occurred, the number of stationary patients being 188, in forty-eight of whom various major operations had been performed. The author ascribes this favourable change to his reforms in the management of the hospital. Of what character these reforms have been may be clear from the following general conclusions at which Dr. Koretzky has arrived. 1. Erysipelas is a contagious disease and yields to antiseptic treatment when this is carried out with the utmost strictness. 2. In all infected hospitals (of which the Kremenchtug Zemsky Hospital is a very good specimen), the use of spray is necessary. 3. Erysipelas is communicated from one patient to others through direct contact of an infected wound with a healthy one, or, and this is the most important point, through the hands of the attendants (surgeons, assistants, nurses, &c.). The attendants' hands are the main carriers of contagion; therefore their cleanliness cannot receive too much attention. 4. There exists a large group of progressive inflammatory processes which are all essentially erysipelatous. To this group belong whitlow, the acute purulent oedema of Pirogoff, lymphadenitis and lymphangitis of various kinds, phlegmonous abscesses, puerperal processes, &c. 5. The treatment of erysipelas consists (a) in prophylaxis, strictest cleanliness of everybody and everything, antiseptic precautions, isolation of the patients operated on from the subjects attacked by the diseases just mentioned; and (b) in therapeutic measures, antiseptic remedies used externally and internally. The author eulogises especially the local application of iodoform and ice.

V. IDELSON, M.D.

821. *Alpago-Novello on Ischuria from Hypertrophy of the Prostate. Repeated Suprapubic Puncture of the Bladder: Cure.*—The author (*Gazz. Med. Ital. Prov. Venete*, April 28, 1883), maintains that suprapubic puncture of the bladder is a much safer proceeding than is usually taught. He narrates the case of an old man suffering from retention of urine from hypertrophy of the prostate, in whom it was impossible to pass a catheter; he punctured the bladder 3 or 4 centimètres above

the superior margin of the pubes to the left of the linea alba, with a small straight trocar 2 millimètres (.078 in.) in diameter, without preliminary incision of the skin. The patient felt scarcely any pain. The cannula was pushed well in to the bladder towards the neck, the sick man lying on his side; two litres of urine were drawn off, the cannula extracted and the puncture covered with a bit of sticking-plaster. The next day the bladder was again punctured very nearly in the same place, twice, morning and evening, and on the day following once more. A catheter was then passed, and gradually the patient recovered the power of passing urine. The author says any incision of the skin before inserting a small trocar is unnecessary. A fine straight trocar answers very well. The safety and facility of this operation give it great advantages over forcible passage of a catheter. Prof. Scarenzio also recommends that this operation should be performed when serious difficulty is found in passing a catheter, and says that capillary puncture of the bladder is attended with no risk, even if repeated several times a day. Extravasation of urine has never been known to take place, the puncture of the bladder contracting and healing at once.

822. *Ribus on Cold Phenicated Baths in the Treatment of Surgical Inflammatory Lesions.*—Dr. P. D. Ribus publishes (*La Independencia Medica*, and *El Siglo Med.*, April 15) seven cases showing the advantages of this treatment by frequently repeated cold phenicated baths. The first case was one of diffused inflammation of the hand and forearm, with high fever, diarrhoea, and intense pain. The hand was freely lanced, but, in spite of poultices and sedatives, the suffering was very great. Dr. Ribus then ordered cold baths (2½ per cent. of carbolic acid) of twenty minutes' duration every three hours, the hand and arm being covered with compresses of the same solution. The patient did remarkably well, and experienced almost at once great relief. The antiseptic and astringent effects of the baths are of indisputable utility in practice, as well as theoretically indicated.

G. D'ARCY ADAMS, M.D.

823. *Roser on Angina Ludovici.*—Professor Roser, of Marburg, writes (*Deutsche Med. Wochens.*, March 14) on the new species of inflammation described by Ludwig, which has its seat in the submaxillary gland. Niemeyer and others, in describing the disease, have confused it with inflammation arising from the lymphatic glands, and with disease of the lower jaw, but Ludwig distinctly stated that he found no implication of the lymphatic glands. The cases which he saw were all unusually severe, and generally ended in death, but at the present day a fatal ending is an exception to the rule. The swelling manifests itself externally in the neck, and internally between the tongue and the gum. In severe cases the mouth can hardly be opened, and the oedema which accompanies the inflammation may render the diagnosis difficult. In Ludwig's time, the treatment of deep abscesses by the knife was unknown, so that he does not mention it; but Professor Roser has treated all his cases by early incision, using the forceps to reach the deep-seated pus, and he attributes the frequency of his recoveries to the early evacuation of the abscess. Swelling of the lymphatic glands may be mistaken for Ludwig's angina, but it does not pass so readily to the floor of the mouth as the swelling of the salivary glands must necessarily do. An abscess of the gum or an

otitis of the lower jaw must also be distinguished from this special disease; and when the patient has been seen from the beginning of the swelling, this is more easy than when the surgeon is suddenly called to a condition of great swelling and œdema, perhaps threatening suffocation. In such a case, the evacuation of the pus has to be made first, and the diagnosis of its source afterwards. The pus which is evacuated from the salivary gland is very offensive, probably on account of some salivary ferment, and this fact will aid diagnosis. This disease is probably the same as Dupuytren's 'Phlegmon large du cou,' Nélaton's 'Phlegmon latéral du cou,' and Stromeyer's fibrinous phlegmon at the margin of the lower jaw. It will be useful to inquire what observations have been made in hospitals on this special epidemic disease, and what appears to be the cause of it. It is most likely caused by some parasite, but the form is not yet known.

824. *Kumar on Embolic Gangrene.*—Dr. Kumar relates (*Wiener Med. Blätter*, March 8) a case of embolic gangrene from the surgical department of the Wieden Hospital. A woman, 60 years of age, on going upstairs, felt suddenly a violent pain in both lower extremities, and could with difficulty reach her bed, where she lay fourteen days before being admitted to hospital. On admission the toes and the whole of the right foot were shrunken and dry, and the leg lividly discoloured half way to the knee, with a red line of demarcation bounding a tract of œdematous swelling which lay above. On the left side the great toe only was affected. The right femoral artery was felt as a solid cord reaching above Poupart's ligament, the left still pulsated a little, the heart was enlarged vertically, the pulse small, and all the arteries rigid. The severe pain was eased by morphia injections, and the gangrenous parts disinfected by strong carbolic acid and covered with a plaster and tar bandage (Gypstheer); but the gangrene mounted gradually as far as the right knee and the middle of the left calf, and bed sores and cystitis had complicated the case before death occurred six weeks after admission. Morphia injections were the only treatment, besides the local disinfection, and unsuccessful attempts to prevent decubitus. [There is no record of an autopsy.—*Rep.*]

825. *Gussenbauer on a Pancreatic Cyst.*—At a meeting of the Society of German Physicians in Prague on March 9 (*Wiener Med. Blätter*, March 22) Professor Gussenbauer showed a man, 40 years of age, on whom he had operated for a cyst of the pancreas. An incision was made in the median line, and the stomach detached in part from the transverse colon; the wall of the cyst was then fixed to the opening in the abdominal wall, to prevent escape of its contents into the peritoneum, and 1,900 cubic centimètres of fluid, which proved to be altered blood, were evacuated. A considerable amount of fluid escaped from the wound during the process of healing, and caused an eczematous eruption on the skin, such as is seen after the formation of gastric fistula, showing the fluid to be digestive. On experiment, it was found to digest albumen and to change starch into sugar, so that its pancreatic nature was beyond a doubt. A fistula still existed, leading to a small cavity, from which a little pancreatic fluid exuded.

826. *Wolff on Trophic Disturbances in Primary Affections of the Joints.*—At the meeting of the Berlin Medical Society, on February 28 (*Deutsche*

Med. Wochens., March 14) Herr Wolff spoke on trophic disturbances in primary joint-affections, pointing out that the alteration in the limb is not always shortening, but very often lengthening; and that it cannot therefore depend, as was formerly supposed, on interference with the epiphysis. He was inclined to ascribe it to reflex nervous influence. In the next meeting, on March 7, Herr Israel said he had seen several cases such as Herr Wolff had mentioned, but that he did not agree with his explanation of them, as he had found lengthening of the limb without any joint-affection. There were even cases of phlegmonous inflammation, in which an increase of growth had resulted without an affection of the bone. Herr Wolff replied that even the phlegmonous case might involve accompanying periostitis, but that he did not pretend to give an explanation of the facts he mentioned.

827. *Senator on Obstruction of the Veins of the Abdomen and Lower Limbs.*—Herr Senator showed a case to the Berlin Medical Society on March 21 (*Deutsche Med. Wochens.*, March 28) of an extremely rare affection of the veins of the abdomen and lower extremities. These veins, enormously dilated and tortuous, presented the appearance of an unusually well-marked so-called caput Medusæ. None of the abdominal organs were diseased, but the obstruction was referred to the iliac veins. The patient had received a bullet in the shoulder at Gravelotte, which could not be extracted in spite of repeated trials. It was now felt by the patient in the pelvis, where it produced those symptoms—less no doubt by actual pressure on the veins than by setting up inflammation, which resulted in adhesions and cicatrices. Virchow had never seen a similar case.

Alice Ker, M.D.

MEDICINE.

RECENT PAPERS.

828. MADER.—Vomiting in Perforating Ulcer of the Stomach. (*Wiener Med. Blätter*, March 22.)

829. MADER.—The Curability of Consumption. (*Ibid.*, March 8.)

830. SCHWERIN.—A Case of Mumps with Delirium. (*Deutsche Med. Wochens.*, March 7.)

831. PEL.—The Diagnosis and Prognosis of the Liver. (*Deutsche Med. Wochens.*, March 7.)

832. ALLEXICH.—Epidemic Parotitis. (*Gazz. Med. Ital. Prov. Venete*, April 7.)

833. RENDU.—Acute Pericarditis. (*Gazz. Med. Ital. Prov. Venete*, No. 21.)

834. TORRE DE LA ABELA.—Trichinosis in Malaga. (*El Sentido Catol.*, April 8.)

835. NOTHNAGEL.—Diabetic Coma. (*Allegem. Wien. Med. Zeitung*, No. 10, 1883.)

836. BAMBERGER.—Biliary Cirrhosis of the Liver. (*Allegem. Wien. Med. Zeitung*, No. 49, 1882.)

837. SCHRÖTTER.—Musical Cardiac Murmurs. (*Allegem. Wien. Med. Zeitung*, No. 1, 1883.)

838. SANSOM.—The Treatment of Some Forms of Valvular Disease of the Heart. (*Brit. Med. Jour.*, Feb. 1883, p. 263.)

839. WHIPHAM.—Erythematous Eruption in Scarlet Fever. (*Brit. Med. Jour.*, April, p. 771.)

840. MACKENZIE.—The Pathology of Diabetes. (*Brit. Med. Jour.*, April, p. 655.)

841. CROWFOOT.—Simulated Scarlet Fever. (*Brit. Med. Jour.*, April, p. 729.)

842. WEST.—Purulent Pericarditis treated by Paracentesis and Free Incisions: Recovery. (*Brit. Med. Jour.*, April 1883, p. 814.)

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Under these circumstances, we cannot sufficiently commend Messrs. ACKERMAN-LAURANCE for the decision, which we learn they have lately arrived at, namely, only to ship their special brand of 'Dry-Royal' Saumur Champagne to those houses who are willing to supply it to the public as imported, that is, with the brand of the wine and name of the shipper on the cork and label as a guarantee of quality, a course adopted many years ago by shippers of the finest champagnes, whose brands are now so celebrated.

So far as Messrs. ACKERMAN-LAURANCE are concerned, we should hope for and predict a like result, for we can bear testimony to the excellent quality of their 'Dry-Royal' brand of Sparkling Saumur, and consider the wine as pure, wholesome, and exhilarating as the most expensive champagne, while it can be obtained at about half the cost of the latter, namely, three shillings a bottle, a price which brings it within the reach of all consumers of sparkling wines."

843. ALLEN.—Bilharzia *Hæmatobia*. (*Lancet*, April, p. 660.)

844. SÉE.—The Pulmonary Complications of Erythema Nodosum. (*Le Progrès Méd.*, Nos. 15 and 16.)

845. CORNILLON.—Hæmatemesis from Washing out the Stomach. (*Le Progrès Méd.*, Nos. 15 and 16, 1883.)

846. KINNICUTT.—Purulent Inflammation of all the Great Serous Cavities. (*New York Med. Record*, April 21.)

847. CAPITAN.—Albuminuria in Healthy Persons. (*Recherches Experimentales et Cliniques sur les Albuminuries Transitoires*, 1883.)

848. DUGUET AND DERIGNAC.—The Pharyngeal Complications of Typhoid Fever. (*Le Progrès Méd.*, 1883.)

849. CHARCOT.—Cervical Pachymeningitis. (*Le Progrès Méd.*, 1883.)

850. CHARCOT.—Double Sciatica in a Cancerous Patient. (*Le Progrès Méd.*, No. 18, 1883.)

851. MAGNAN.—Verbal Deafness. (*Le Progrès Méd.*, No. 20, 1883.)

852. BURGER.—Addison's Disease. (*Allgem. Med. Central-Zeitung*, March 1883.)

853. BALLET AND DUTIL.—Trophic Disturbances of the Skin in Tabes. (*Le Progrès Méd.*, No. 20, 1883.)

ART. 828. *Mader on Vomiting in Perforating Ulcer of the Stomach*.—Is vomiting present in peritonitis from perforation of ulcer of the stomach? Dr. Mader, of Vienna, puts this question (*Wiener Med. Blätter*, March 22) in reference to an article by Professor Ebstein, published in No. 4 of the *Blätter*, in which he gives the absence of vomiting as a certain diagnosis of gastric ulcer. But one case in which vomiting had taken place would render this law useless; and even in a case given by Ebstein as an illustration, the vomiting was present until fifty hours before death, but he considered the perforation to have been caused by the vomiting, and not *vice versa*. Where the walls of the ulcer are very thin, and great distension of the stomach is present, the contents will certainly pass more easily into the abdominal cavity than through the cardiac orifice; but a perforation small enough to allow only gas and fluids to pass may be closed by the antiperistaltic action of the stomach, so that most of the gastric contents will pass by the œsophagus. Adhesions may also have been formed between the site of the ulcer and the neighbouring organs, as happened in Ebstein's case, so that the fluid is prevented from passing at once into the peritoneal cavity. In Dr. Mader's case, a young woman, aged 24, well-nourished and healthy, with the exception of some degree of chlorosis, had felt moderate pain in the left side for four days, with constipation for two days. Just before admission the pain had suddenly become greater, and the pulse was more frequent; but the amount of fever was small, and the paleness no more than was customary. The abdomen was tense, but not distended, and light percussion, which was all that could be borne, found dulness on the left side. Next day there was a little bilious vomiting, but the subjective symptoms were less. On the day following, however, the abdomen was distended and very tender, the patient was pale and collapsed, vomiting continued all day, and in the night she died. Free gas and purulent fluid with gastric contents were found in the peritoneal cavity; the stomach was collapsed, and in its anterior wall was a perforation, about the size of a pea on the peritoneal surface, twice as large on the mucous. There was no attempt at cicatrization. The chlorosis,

combined with some slight catarrh of the stomach, had evidently caused the formation of an ulcer which had given rise to no pain until the process reached the serous coat, four days before admission. During the time of moderate pain, some adhesions had evidently been formed with neighbouring organs, so that when the serous membrane gave way, at the commencement of severe pain, neither gas nor fluid escaped at once. Inflammation of reaction then set in, and the process seemed to stand still, until the slight adhesions gave way, and the escape of the contents of the stomach caused death. Vomiting was present almost till the end.

829. *Mader on the Curability of Consumption*.—Dr. Mader, of Vienna, writing on the curability of pulmonary tuberculosis (*Wiener Med. Blätter*, March 8), remarks on the paradox that medical men call tuberculosis incurable at the bed-side, and yet see many cases of cured pulmonary tubercle on the *post mortem* table. Many such cases may escape observation during life, by belonging to persons who do not call in a physician when they are first taken ill, or who, if they do come to hospital, leave it only a little, if at all, improved, and complete their convalescence at home. He mentions a case, which he saw cured in hospital, of a lad, aged 15, who was admitted with hæmoptysis, high fever, and unmistakable signs of phthisis at the apices of the lungs, dulness, cracked-pot sound, &c. This condition lasted some weeks, death being daily expected, when the patient, after about six weeks in hospital, began to amend; the fever left him, and he was discharged free from cough, but with some dulness and sharpness of respiration still remaining. Fourteen months afterwards he was admitted in much the same state as the first time, and death occurred in ten days. Tubercles were found in the upper part of both lungs, in all stages, from grey and yellow to caseous and calcareous; the old cured ones corresponding to the former attack, and the recent ones to the illness which carried him off. Bronchiectasis was also present to a large extent. After leaving the hospital for the first time, his work obliged him to stand in water a good deal, and the resulting bronchial catarrhs probably softened the healed tubercles, and made them fresh centres of infection. No bacilli were found in the masses coughed up during his second attack; but, as they may have come from the large dilatations where the tubercular process had ceased, the fact only shows that a failure to find them does not exclude the possibility of tubercle. Dr. Mader has seen other cases of cure; none, however, so striking as this one.

830. *Schwerin on a Case of Mumps with Delirium*.—At a meeting of the Verein für innere Medizin, Jan. 22 (*Deutsche Med. Wochenschr.*, March 7), Herr Schwerin communicated a case of mumps in a man, aged 24, where the parotid swelling was very great for the first five days, but without fever or other general disturbance, and the patient was not confined to bed. On the sixth day the temperature rose to 100.4°, in the evening to 101°, and he complained of pain in the right testicle. The orchitis rapidly increased, until the testicle was three times its normal size. In three days the parotid swelling had diminished, but the high temperature and other feverish symptoms continued, and, in spite of salicylic treatment, delirium appeared at night, with extreme loquacity during the day. He had not slept since the beginning of the fever. He had been in

the habit of drinking, although not lately, and the question was whether it might not be a case of delirium from that cause. Herr Leyden was called in consultation, and considered it to be a case of epiphrastic delirium. Two grammes (31 grains) of chloral, given in two doses, half an hour apart, produced sleep at once, which lasted, with short interruptions, for twelve hours, and after which he felt nearly well. Convalescence was rapid. Herr Leyden remarked on the strangeness of such well-marked delirium in such a slight illness, saying that such cases differ from the delirium of drunkards in having no tremors. The prognosis is always favourable, as chloral cures at once. Herr Fraentzel mentioned the still delirium which sometimes occurs after recurrent fever, in which patients may be suddenly seized with suicidal mania.

831. *Pel on the Diagnosis and Prognosis of Cirrhosis of the Liver.*—Dr. Schumacher, of Aix-la-Chapelle, communicates (*Deutsche Med. Wochens.*, March 7) a paper by Dr. Pel, of Amsterdam, on the diagnosis and progress of cirrhosis of the liver. In this disease, which presents many difficulties, the two chief diagnostic points are obstruction to the circulation in the vena portæ, and the presence of an exciting cause—e.g. alcoholic excess. But frequently the *post mortem* examination reveals appearances which were not suspected during life. Case 1, 25 years of age, and formerly quite healthy, never having indulged in alcohol to excess, was admitted on account of exudative pleurisy of the right side after pneumonia. No signs of abdominal trouble were present, and the liver was distinctly felt below the ribs. After death, advanced cirrhosis of the liver was found, with enlargement of the spleen and dilatation of the abdominal veins. Case 2, far gone in phthisis, complained of considerable emaciation for some weeks, with nocturnal rise of temperature to 40° C. (104° F.), diarrhœa, and severe abdominal pain. The abdomen was very tender even on superficial palpation, meteorism was present at the upper part, dullness, varying with position, at the lower, and fluctuation was distinct. At the necropsy advanced cirrhosis of the liver, with ascites, was found instead of the expected tubercular peritonitis. The signs of portal obstruction in cirrhosis, once established, scarcely ever disappear entirely, although they may diminish somewhat. Nature, however, sometimes cures even those. Case 3, given to alcohol, not syphilitic, and in a state of health otherwise satisfactory, fell ill with disturbance of the appetite and of the bowels. In four weeks first the abdomen and then the legs began to swell, and on admission to the hospital there was considerable distension of the abdomen, with no appreciable enlargement of the liver and spleen. The lungs and heart were normal. Three distended veins lay between the umbilicus and the right epigastrium; no tumour could be made out; dullness on percussion varied with position, and the secretion of urine was only 250 to 500 c.c. daily. The specific gravity was 1023 to 1025, and it contained urates and much indican, but no urobilin, the excess of which has been said to be pathognomonic of cirrhosis. A month after admission the conditions were so much worse that the end seemed near; but two weeks later the urine increased to 2200 c.c., the ascites began to diminish, and, in spite of a sero-fibrinous exudation into the pleura, the patient left the hospital perfectly well two months and a half after his admission. Although this case was not

verified by a necropsy, the only symptom that did not indicate cirrhosis was the absence of urobilin.

Alice Ker, M.D.

832. *Allexich on Epidemic Parotitis.*—The author says (*Gazz. Med. Ital. Prov. Venete*, March 31, 1883) that the evident analogy of parotitis to the acute exanthemata, its frequent development in the course of these, or during the various other morbid processes due to acute infection, lead us to conclude that the causal connection between it and the above-named diseases exists in the alteration of the blood-crisis by a specific infecting virus. The inflammation of the parotid is in these cases secondary, and, together with other local manifestations due to the original malady, furnishes an additional proof of blood-poisoning from the introduction into the organism of parasitic life. Epidemic parotitis is etiologically identical with this form of parotid inflammation, and, like it, is due to an infecting virus; only by a simple local alteration it shows the character of the prevailing epidemic. Parotitis never diffuses itself in a population unless at the same time, and in the same district, some other disease becomes developed in the epidemic form. Parotitis, which occurs as a complication in the course of almost all infectious maladies, may appear while they are epidemic; and, while different transitory morbid causes determine grave maladies (differing according to the specific virus), and leading to a great mortality, in the same time and place other organisms more fortunate, under the same malefic infecting influence, are not seized with the malady which should result from it, but from a milder form (parotitis). The proofs given by O. Weber that erysipelas and hospital gangrene may cause by their exhalations tumefactions of the parotid; the knowledge that where parotitis is endemic other endemic maladies presenting an infective character prevail; the fact of having found that parotitis is developed in the epidemic form only when another acute infectious disease is rife, lead the author to believe that epidemic parotitis is determined by a special infecting virus, which in every organism gives rise to the same morbid form, but which may be manifested in the course of epidemics of all acute infectious diseases in those subjects who, from special circumstances, having the faculty of resisting the true infection, cannot altogether elude its influence. Cynanche parotidea, then, may be rubeolous, scarlatinal, variolous, &c., as it is developed under the influence of one or other of these epidemics, and it would especially accompany them in the spring and autumn, when the damp, cold, and atmospheric changes would render the parotid more liable to be affected.

833. *Rendu on Acute Pericarditis.*—Dr. Rendu thus summarises (*Rivista degli Ospitali Civili di Genova*, and *Gazz. Med. Ital. Prov. Venete*, March 21) the symptoms of great pericardial effusions requiring surgical interference.

1. The increase of precordial dullness is a sign of great value, especially downwards towards the diaphragm.
2. Signs of pulmonary compression, exaggerated vibration, indicate distension of the pericardium backwards towards the posterior mediastinum.
3. Œdema of the precordial parietes, accompanied often by dilatation of the superficial veins of the thorax, shows an impediment to the parietal circulation.
4. Lastly, the 'pulsus paradoxus' is a less con-

stant sign, which by itself has no absolute value, but which is most frequently observed when the expansion of the heart is hindered by a large pericardial effusion.

He concludes that the temperature is no guide, contrary to the rule in acute disease. He insists on the necessity of operation when dyspnoea, cyanosis, and the distress of the patient make suffocation appear imminent. He prefers direct puncture of the pericardium with the aspirator to making a preliminary incision, because of the risk of setting up suppuration of the wound. As to the site of puncture, he says that, considering that the liquid always accumulates at the base of the pericardium, towards the diaphragmatic region, he asserts the lowering of the gastric sonority is the best indication of the limit of the collected fluid, and, as the heart is drawn upwards and backwards, however little the diaphragm is lowered, there remains between the apex and the diaphragm an appreciable space. In this point, then, the puncture will be most safely made. In one of his patients he punctured the pericardium in the sixth intercostal space, eight centimètres from the sternum, in the mammary line, and was astonished at the simplicity of the operation. To the objection that the pleura or lung might be injured, he replies that by the pathological conditions of the pericardium the edge of the lung is displaced, and little harm could be done to the pleura with the aspirating needle.

834. *Torre de la Abela on Trichinosis in Malaga.*—The author describes (*La Clinica de Malaga and El Sentido Catol.*, April 8) an epidemic of trichinosis which, at the time of the report, had affected twenty-five individuals and caused three deaths. All the cases presented well-marked symptoms, such as have been observed in other epidemics. Prolonged salting and fumigation of the meat is not sufficient to destroy the parasites; the meat should be thoroughly cooked; in this opinion he is in accord with all observers. The treatment is unsatisfactory. Purgatives, especially calomel, are first given. By this means, the parasites which may be in the intestinal canal are expelled. After their migration to the muscles, no remedy seems to affect them. The general treatment consists in giving tonics and liberal diet. He finds digitalis especially useful as a cardiac tonic. The pulse is a good guide to the gravity of the case: it often becomes quick, irregular, and very weak, without any great rise of temperature.

G. D'ARCY ADAMS, M.D.

835. *Nothnagel on Diabetic Coma.*—An interesting case of coma in association with diabetes and nephritis is reported (*Allgem. Wien. Med. Zeit.*, No. 10, 1883) from the clinic of Professor Nothnagel. The patient—under treatment for metrorrhagia, with polyuria and albuminuria—suddenly became comatose, with dyspnoea. The heart and lungs were found healthy. There had been no previous symptoms of uræmia. The urine, tested by Lieben's method—viz. treated with iodide of potassium in the presence of caustic potash—gave the characteristic odour of iodoform, indicating the presence of acetone. In his remarks upon the case, Professor Nothnagel pointed out that dyspnoea in association with diabetic coma has been well described by Kussmaul and Frerichs; sometimes occurring with enfeebled cardiac action, and sometimes with a series of initial symptoms of disturbance of digestion or respiration: in such cases acetonaemia has generally been easily diagnosed from the odour

of acetone in the breath, or from its presence with aceto-acetic acid in the urine. From recent experiments, however, it may be considered to be proved that neither of these substances is the direct cause of the condition induced, but that they must both be regarded as products of the decomposition of some hitherto unknown chemical substance. Other possible causes for the dyspnoea may be looked for in the changes in the kidney, producing a form of uræmic coma, or in the occurrence of fat-embolism. So long, however, as the chemical changes in the blood remain unexplained, no rational treatment can be employed.

836. *Bamberger on Biliary Cirrhosis of the Liver.* Professor Bamberger (*Allgem. Wien. Med. Zeit.*, No. 49, 1882), enters into the clinical aspects and the diagnosis of this form of cirrhosis, and brings forward a case in illustration of it. The patient had suffered for two years from jaundice, with some general wasting, but no local pain; the urine was deeply coloured, and the stools always light, and at times quite colourless. Distinct enlargement of the liver could be felt, and at one point distinct puckering of the right lobe. The spleen was also enlarged. There was no ascites whatever. The occasional appearance of bile in the motions proved that the obstruction was not complete. In considering the diagnosis of such a case, he rejects fatty and amyloid liver at once. Carcinoma of so long duration, with only partial wasting, would be unlikely. Continued catarrh of the biliary passages gives rise to concretions and to pain. Simple cirrhosis might be diagnosed, were it not for the absence of ascites. A form of cirrhosis, however, exists which is unaccompanied by ascites, viz., biliary cirrhosis, a form which has its origin in the biliary passages alone. It may be induced by catarrh, followed by concretions, but consists essentially of an overgrowth of connective tissue about the ducts. Hence the important and indicative symptom is the jaundice, ascites being only a secondary phenomenon. The prognosis as to the duration of such a case is uncertain, and the treatment must tend in the direction of facilitating the flow of bile and of regulating digestion by diet and by natural alkaline waters.

837. *Schrötter on Musical Cardiac Murmurs.*—As a result of observations extending over a considerable period of time, Professor Schrötter communicated to the Vienna Medical Society (*Allgem. Wien. Med. Zeit.*, No. 1, 1883), his views on the causation of musical murmurs heard over various parts of the heart's area. Following Hamernik, he regarded the fine, musical, high-pitched note sometimes observed over the left ventricle as due to the abnormal tension of one or more chordæ tendineæ, and demonstrated in illustration thereof the heart of a man of 40, in which a fine tendinous thread traversed the cavity of the left ventricle. In some other cases, however, viz., those of musical murmurs heard over the aortic area, similar conditions have been observed, especially in perforated aortic valves, a thin tendinous thread corresponding to the free edge of the valve being left free to vibrate in the current of blood. Such perforated valves are not uncommon, but it is only in the cases where the thread-like margin is able to be vibrated that the musical sound is produced.

E. CLIFFORD BEALE, M.B.

838. *Sansom on the Treatment of Some Forms of Valvular Disease of the Heart.*—Dr. Sansom, in the *Brit. Med. Jour.*, Feb. 1883, p. 243, continues his Lettsomian Lectures, the subject of the third lecture,

being mitral stenosis. Viewing the mitral aperture from the auricle, there are noticed in organic disease the 'button-hole' orifice and the 'funnel-shaped' orifice, the latter being much the rarer form. Upon the left auricle the consequences of mitral stenosis are very manifest. It is usually not only dilated, but hypertrophied. The murmur of mitral stenosis occupies the diastolic period, and ends suddenly; the murmur of mitral regurgitation is systolic in time, and never ends abruptly. In a few cases, the murmur of mitral stenosis may be simulated by that of aortic regurgitation, when this is conducted towards the apex. Reduplication, or a seeming reduplication, of the second sound is to be noted in at least one-third of the cases of mitral stenosis, and only rarely in other conditions. A third sign of importance in establishing the diagnosis of mitral constriction is thrill, which is præsystolic in time. The observations on the pulse in mitral stenosis are somewhat contradictory. Dr. Sansom finds the pulse, as a rule, notably irregular. The evidence afforded by the cardiograph when mitral stenosis is suspected is very valuable. As to the clinical evidence of the origin and course of the morbid changes which bring about the obstructive lesion, Dr. Sansom thinks that it is associated with the less pronounced forms of rheumatism, with those insidious cases in which the articular affections are not marked. As to treatment, in many cases, rest, combined with the administration of nutrients and tonics, with digitalis, have restored the condition formerly existing for a considerable period. Also the repeated abstractions of small quantities of blood are very valuable in mitral stenosis. The tension of the right heart may be sensibly relieved even by a leech or two applied over the pericardium. Embolism in some sort is a source of danger, to be considered in a large proportion of cases of mitral stenosis.

839. *Whipham on Erythematous Eruption in Enteric Fever.*—Dr. Whipham (*Brit. Med. Jour.*, April 1883, p. 771) recorded two cases at a meeting of the Clinical Society of an eruption resembling that of scarlatina occurring in patients who were also affected with ulceration of Peyer's patches. One case was that of a man aged 36, who was admitted with a bright erythematous rash on the trunk, legs, and arms, and complained of sore-throat and headache. At first there was constipation, but a purge was given, and diarrhoea then continued until patient died, death taking place four days after admission. *Post mortem* examination showed ulceration of Peyer's patches, but there had never been any typhoid eruption. The second case occurred in a child aged 4 years, who was admitted with a brilliant erythematous rash over the body. Ten days after admission characteristic spots of typhoid fever appeared, and in nine days the child died; *post mortem* examination showing extensive ulceration of Peyer's patches, with swelling of mesenteric glands. A discussion ensued, and Dr. Broadbent said that, when a scarlatinal rash came out in a case of enteric fever, he regarded it as an evidence of concurrence of the two diseases.

840. *Mackenzie on the Pathology of Diabetes.*—Dr. Stephen Mackenzie, in the *Brit. Med. Jour.*, April 1883, p. 655, opens a discussion on the pathology of diabetes, paying special attention to diabetic coma. In the author's experience coma and phthisis are the two most common modes of termination of diabetes. Nearly all cases that die, below the age of twenty-five, die from coma. The mean duration of

cases that die from coma is much less than of those that die from other causes. The mode of onset of the coma is noted, and its special features enumerated, the breathing being described as an '*air-hunger*.' Dr. Mackenzie says that, though acetone has been detected in some cases of diabetic coma, it does not appear to be present in any considerable quantity in many, and the evidence is against it being a general explanation of the coma; but he considers that intoxication by some such poison, with a special affinity for the sympathetic system, developing in the tissues or blood, is the most likely direction in which we shall have to search for the cause of diabetic coma. Dr. Mackenzie agrees that Dr. Hilton Fagge's theory of the dehydration of the blood, as an explanation of the coma, deserves further consideration.

841. *Crowfoot on Simulated Scarlet Fever.*—In the *Brit. Med. Jour.*, April 1883, p. 729, an article is given on simulated scarlet fever, and reference made to a recent report by Mr. Crowfoot, the health-officer at Beccles, where an eruptive disease existed, very similar in some respects to scarlet fever; the rash and initial fever were the same as in scarlet fever, but there was no desquamation of the cuticle nor any enlargement of the cervical glands. Convalescence was rapid, and no sequelæ followed any of the cases. [Some very instructive papers were published in the *Brit. Med. Jour.*, Jan. 1879, pp. 11, 75, and many articles bearing further on the subject are noted in section 1631: 5 of the *Medical Digest*.—*Rep.*]

842. *West on Purulent Pericarditis treated by Paracentesis and by Free Incisions, with Recovery.*—Dr. Samuel West, in the *Brit. Med. Jour.*, April 1883, p. 814, reports a case of a boy, aged 16, who had pericardial effusion. The symptoms became so urgent that paracentesis was performed, and pus was discharged. Three days later paracentesis was again performed, and subsequently the pericardium was laid freely open, washed out, and a drainage tube inserted. The temperature never rose, and the boy recovered completely in five weeks. A discussion ensued, and Dr. West briefly related the history of the operation from its first suggestion by Riolan in 1649. [A similar case is noted in the *Medical Digest*, Sec. 760: 3, performed by Dr. Rosenstein, the first recorded, an account of which appeared in the *Med. Times and Gazette*, March 1881, p. 323.—*Rep.*]

843. *Allen on Bilharzia Hamatobia.*—Dr. Allen, of Pietermaritzburg, in the *Lancet*, April 1883, p. 660, draws attention to a report of a meeting of the Royal Medical and Chirurgical Society, which appeared in the *Lancet*, November 18, 1882, in which Dr. Cobbold refers to a letter (see *Lancet*, July 15, 1882) from Dr. Allen on the subject of Bilharzia hamatobia. Dr. Allen recommends the use of injections into the bladder of a saturated alcoholic solution of santonin. This plan, Dr. Cobbold states, is too heroic, but there seems to be a difference of opinion on the subject, which experience can only settle.

RICHARD NEALE, M.D.

844. *Sée on the Pulmonary Complications of Erythema Nodosum.*—M. Germain Sée (*Le Progrès Méd.*, Nos. 15 and 16, 1883) reports five cases of erythema nodosum, complicated by pulmonary accidents, and formulates the following conclusion. 1. Erythema nodosum is a specific fever analogous to the eruptive fevers, and not a cutaneous manifestation of rheumatism. 2. This fever, generally benign, may (like the eruptive fevers) be complicated by disorders of the respiratory apparatus. 3. Pleurisy is the more frequent complication, but broncho-

pneumonia has also been observed. 4. This pleurisy does not appear to present any special characters. 5. Nevertheless, in the only fatal cases, it is noteworthy that it was distributed in successive and distinct patches; the fibrinous exudation was abnormally thick and abundant, while the fluid was small in amount. 6. These accidents are ordinarily of not unfavourable prognosis, but in two cases death was the consequence. 7. These complications are not rheumatic, but depend directly on the specific nature of the disorder.

845. *Cornillon on Hæmatemesis from Washing out the Stomach.*—Kussmaul, Bucquoy, and Broca recommend washing out the stomach by the long tube in cases of simple chronic gastric ulcer. Germain Sée is opposed to this practice from the risk of producing hæmorrhage and of tearing the base of the ulcer. Cornillon of Vichy reports a case (*Le Progrès Méd.*, No. 17, 1883) in which severe hæmatemesis was so produced; but he maintains that the practice is good in old standing cases, if care be taken not to raise the funnel above the head, and not to pour into the stomach more than half a litre ('880 pint) of water.

846. *Kinnicutt on Purulent Inflammation of all the Great Serous Cavities.*—Kinnicutt (*New York Med. Record*, April 21, 1883) records the case of a well-nourished male, aged 21, who was admitted into hospital after ten days' illness, with respiration 40, pulse 138, temperature 104° 8', and dullness on percussion with distant breathing over the lower three-fourths of the left side of the chest. On the following day the signs of pleural effusion had increased, and 16 ounces of creamy pus were removed by aspiration. The heart-sounds were feeble, the impulse was absent, but the area of cardiac dullness could not be defined, owing to the pleural effusion; nevertheless, pericardial effusion was suspected. Aspiration was repeated the following day with the same result, but without improving the patient's condition. He died on the sixth day after admission. At the necropsy there was no skin-eruption, nor œdema. The pelvic peritoneum was congested, and there was a small amount of pus and lymph in this situation. The right pleural cavity contained 22 ozs. of sero-fibrinous fluid; the left pleural cavity 74 ozs. of sero-pus. The right lung was congested and œdematous; the left lung was collapsed, airless, and covered with recent lymph. The pericardium contained 6 ozs. of fibrinous sero-pus; the surface of the heart was covered with recent lymph; the muscular wall and valves were apparently normal. The brain was not examined. With the exception of slight excess of fat in the liver, the other organs were healthy. Microscopic examination showed only cloudy swelling of the renal epithelium, and fatty degeneration of the cardiac muscle. There was no evidence of any source of septic infection, nor of any of the acute infectious diseases, or rheumatism; chronic Bright's disease was also quite excluded by the result of the *post mortem* examination.

847. *Capitan on Albuminuria in Healthy Persons.* Capitan (*Recherches Experimentales et Cliniques sur les Albuminuries Transitoires*. Paris, Delahaye, 1883) examined the urine of 100 healthy soldiers; of these 20 showed a trace of albumen, 22 an uniform or retractile cloud. Of 92 children, 38 showed definite traces of albumen.

848. *Duguet and Derignac on the Pharyngeal Complications of Typhoid Fever.*—Duguet (*Le Progr. Méd.*, No. 19, 1883), at a recent meeting of the

Société Médicale des Hôpitaux, gave an account of the various forms of throat-affections which he had met with during the recent epidemic of typhoid fever in Paris. The most common and the earliest and the slightest is the simple erythematous angina, which sometimes manifests itself before any other sign of the fever. Erysipelatous angina, which may resemble the preceding at first, is much more grave by giving rise to serious œdema of the palate pharynx and aryteno-epiglottidean folds. Such cases may, besides the risk of asphyxia, give rise to ulcerations, abscesses, &c. The ulcers of the throat appear early in the disease; they are generally situated on the anterior pillar, are oval in shape and superficial, like a large aphthous ulcer surrounded by a red zone. These ulcers are of no prognostic significance, occurring alike in severe and mild cases. In Derignac's cases the ulcers were deeper, but in other respects they were the same. They may develop without giving rise to any symptoms, or they may cause pain and dysphagia. Sometimes they do not heal, but give rise to graver troubles, erysipelatous angina, abscess, &c.

849. *Charcot on Cervical Pachymeningitis.*—Charcot (*Le Progr. Méd.*, No. 19, 1883) describes a case of paralysis due to cervical pachymeningitis. He points out that such cases pass through three stages; 1, the neuralgic period, characterised by severe pains and sense of constriction in the chest, a stage which lasts four, five, or six months; 2, the paralytic period in which paralysis occurs, accompanied by muscular atrophy; and 3, the spasmodic period, in which the lower limbs are affected by a spasmodic paraplegia, the result of a transverse myelitis with descending degeneration of the lateral columns. The pathology of this affection is an inflammatory thickening of the dura mater, which may involve to some extent the nerves passing through it and the adjacent end, but in the main the symptoms are due to the compression of the inflamed membrane. Such cases occur independently of any diathesis or specific cause, often as the result of living in a damp place. Ultimately recovery may take place; in the case quoted this occurred partly spontaneously, partly as the result of treatment which chiefly consisted of the actual cautery over the seat of the disease. Afterwards there remained great contraction of the ham-string muscles, but these were divided subcutaneously, and by electricity and friction the patient recovered so far that he could walk about the courts of the hospital and go a mile without great fatigue.

850. *Charcot on Double Sciatica in a Cancerous Patient.*—Charcot (*Le Progr. Méd.*, No. 18, 1883) in a recent clinical lecture, described the case of a woman, aged 61, operated on several times for scirrhus of the breast, who developed severe double sciatica, together with pain in the regions of both anterior crural nerves; the pains were exasperated by the erect position, so that walking was impossible. There was tenderness in the lumbar and sacral region of the spinal column; there was no muscular atrophy, alteration of reflexes, or disturbance of the functions of the bladder or rectum. Double sciatica is always symptomatic, a statement which does not deny that unilateral sciatica may be also. The causes of double sciatica are (a) diabetes, but in this the urine was free from sugar; (b) certain spinal affections, locomotor ataxy and meningo-myelitis, but which would present symptoms that were absent in this case; (c) some alteration in the nerves them-

selves. This would be most readily accounted for by cancerous invasion of the vertebral column causing pressure on the nerves; as there was no evidence of any tumour in the pelvis. Secondary cancer of the spinal column was held by Cazalis to be very common, especially after scirrhus of the breast, but it may also be found in those affected with cancer of the stomach. The presence of double sciatica should contra-indicate operation for tumours of the breast, as metastasis may be inferred. Intense neuralgia in patients at the age for cancer should suggest careful examination of the breasts, the stomach, and the uterus. Pseudo-neuralgic pains are the ordinary clinical signs of vertebral cancer; but a fungous mass may project from the spine, in which case the vertebræ are infiltrated, and the consequences will be similar to those of Pott's disease.

851. *Magnan on Verbal Deafness*.—Magnan (*Le Progrès Méd.*, No. 20, 1883) has related to the *Société de Biologie* the history of a patient who was aphasic, and latterly was affected by verbal deafness. He could not speak or understand words, but he was not absolutely unintelligent; he took pleasure in reading the papers, and understood signs. He could also read handwriting. Thus, when 'thief' was written after his name, he rubbed it out and wrote a less injurious appellation. At the necropsy there were found diffuse sclerosis of the third left frontal convolution and the island of Reil, and a focus of softening occupying the first and second temporal convolutions.

852. *Burger on Addison's Disease*.—Burger (*Allgem. Med. Central-Zeitung*, March 14, 1883) arrives at the following conclusions. 1. The suprarenal capsules are blood-forming glands, and have no important vital functions. 2. They do not stand in any causal relation to the pigmentation of the skin, which occurs not only in Addison's disease but in cachexiæ. 3. All varieties of disease of the capsules may be met with in Addison's disease. 4. Addison's disease depends eventually upon disease of the semilunar ganglia and solar plexus, which is most often caused by disease of the capsules, generally tuberculosis, but may have other causes, or be idiopathic.

853. *Ballet and Dutil on Trophic Disturbances of the Skin in Tabes*.—MM. Ballet and Dutil report (*Le Progrès Méd.*, No. 20, 1883) from the service of M. Charcot and his colleagues three cases of a sort of ichthyosis of the skin of the anæsthetic or hyperæsthetic regions in tabes. The skin was usually reddened, lax, thrown into folds, and the epidermis was increased in amount and sometimes desquamating. They summarise these results in the following propositions. 1. In tabes we may observe permanent trophic disturbances of the cutaneous system. 2. These trophic disturbances are very different in appearance and evolution from those hitherto described. The skin-eruptions (herpes, &c.), ecchymoses, and even perforating ulcer, are the effects of simply transient and accidental phases. Ichthyosis is, on the contrary, a dystrophy of slow evolution, apparently progressive, like the lesions of bone. 3. This dystrophy is manifested by a kind of thickening of the skin, with more or less deepening of its colour, laxity of the integuments, desquamation of the epidermis, the *débris* of which sometimes accumulate so as to form true scales on the surface of the skin. 4. The regions in which these changes are observed are also those in which marked disturbances of sensa-

tion may be found, lightning-pain, anæsthesia, hyperæsthesia, to cold, to pricking, sometimes to simple contact. The extremities are the parts generally attacked. The skin of the back of the hand may come to resemble the skin in pellagra. 5. The loss of the nails and their alterations, as described by Joffroy, Pitres, Roques, and Dorneaux-Juron, seem to be examples of this cutaneous dystrophy, affecting the matrix of the nail.

ROBERT SAUNDEY, M.D.

THERAPEUTICS AND PHARMACOLOGY.

RECENT PAPERS.

854. ALBERTONI.—On the Hypnotic Power of Paraldehyde. (*Riv. di Chim. Med. e Farmaco-tossico e Farmaco.*, Feb. and March, 1883.)

855. ROVIGHI.—Inhalations of Sea-water Spray in Chronic Affections of the Respiratory Apparatus. (*Gazz. degli Ospitali*, April 11 and 15, 1883.)

856. UNNA.—On Ichthyol. (*Deutsche Med. Zeitung*, No. 17, 1883.)

857. CURRIE.—Chian Turpentine in Cancer. (*Edin. Med. Jour.*, May 1883.)

858. BURQ.—The Immunity of Copper-workers from Infectious Diseases. (*Ibid.*, No. 17, 1883.)

859. AUBERT.—Injections of Atropine and Morphia in Anæsthesia. (*Le Progrès Méd.*, No. 17, 1883.)

860. PACZKOWSKI.—On Hydrochlorate of Fuchsaniline in Scarlatinal Nephritis. (*Przegląd Lekarski*, No. 8, 1882.)

861. WOITEKEWICZ.—On Salicylate of Soda in Diabetes. (*Wratch*, No. 43, p. 730, 1882.)

862. KAZANSKY, E. P.—On the Treatment of Pulmonary Phthisis. (*Wratch. Vedomosti*, No. 331, 1882, pp. 3551-4, and No. 533, pp. 3382-4.)

863. JUK.—On the Action of Convallaria Majalis. (*Proceedings of the Kiev Medical Society*, Fasc. 1, 1882.)

864. BRUNNER, M.—On the Disappearance of Erysipelas after Hypodermic Injection of Morphia. (*Medycyna*, No. 7, 1882.)

865. SZREIBER, O.—On a Case of Lupus Treated and Cured by Iodoform. (*Gazeta Lekarska*, No. 27, 1882.)

866. BARAIEFF.—On Chloral in Dental Caries. (*Proceedings of the Caucasian Medical Society*, No. 11, 1882.)

867. DE SANCTIS.—Quinine in Large Doses in Typhoid Fever. (*L'Imparziale*, March 7, 1883, and *Gazz. Med. Ital. Prov. Venete*, March 31.)

868. CERVELLO.—On the Physiological Action of Paraldehyde. (*Il Pisani*, Disp. iv., v., vi.)

869. MORSELLI, Prof.—On the Hypnotic and Sedative Action of Paraldehyde. (*Il Pisani*, Disp. iv., v., vi.)

870. COMIN.—Purpura Hæmorrhagica from Quinine. (*El Siglo Medico*, April 15.)

871. The Treatment of Phthisis with Iodoform. (*Lo Spallanzani*, Jan. and Feb. 1883.)

872. BONATTI.—New Therapeutic Application of Chloral-Hydrate. (*Gazz. Med. Ital. Prov. Venete*, April 7.)

873. SAWYER.—The Therapeutic Uses of Oleates. (*Brit. Med. Jour.*, February, p. 250.)

874. GRANVILLE.—A Prescription for Acute Rheumatism. (*Ibid.*, April, p. 663.)

875. CARSON.—The Treatment of Carbuncle. (*Brit. Med. Jour.*, April 1883, p. 750.)

876. PRITCHARD.—Belladonna as a Prophylactic against Scarlet Fever. (*Lancet*, April, p. 666.)

877. CHAPMAN.—Is 'Distilled Water always the best Vehicle for Eye-Lotions?' (*Practitioner*, May, p. 354.)

878. HAY.—The Value of some Nitric, Nitrous, and Nitro Compounds in Angina Pectoris. (*Practitioner*, May.)

879. SHEEN.—Nitrite of Amyl and Nitroglycerine in Uræmic Asthma. (*Brit. Med. Jour.*, April, p. 811.)

880. DRESCHFELD.—The Treatment of Phthisis by Iodoform. (*Brit. Med. Jour.*, April, p. 817.)

881. HAY.—The Use of Concentrated Solution of Saline Cathartics in Dropsy. (*Lancet*, April, p. 678.)

882. LEWIN.—The Use of Santonin. (*Deutsche Med. Wochens.*, March 21.)

883. ANDRESSE.—Perchloride of Iron in Diphtheria. (*Deutsche Med. Wochens.*, March 14.)

884. BURKE.—Abdominal Inunction during Pregnancy. (*New England Med. Monthly*.)

ART. 854. *Albertoni on Paraldehyde*.—The author's observations, though pretty numerous, were made on only seven insane patients. The conclusions arrived at confirm, in the main, those previously reached by Cervello and by Morselli. Paraldehyde is to be preferred to chloral, because it does not lower the blood-pressure or disturb the circulation. On the other hand, however, it is inferior to chloral in intensity of action, and the patient sooner becomes accustomed to it. The dose given varied from 3 to 9 grammes. High doses, however, 8 or 9 grammes for example, were preferred.

855. *Rovighi on the Inhalation of Sea-water*.—The author finds the inhalation of sea-water spray of great value in chronic affections of the lungs.

WILLIAM R. HUGGARD, M.D.

856. *Unna on Ichthyol*.—Unna (*Deutsche Med. Zeitung*, Nov. 17, 1883, and *Monatsschr. für Prakt. Dermat.*, Nos. 11 and 12, 1882) has used with great success a new bituminous substance containing a large amount of sulphur, and to which the name of ichthyol is given. It is partially soluble in alcohol and ether, and perfectly soluble in these combined. He recommends its use (10 per cent. with vaseline) to paint on the joints in acute rheumatism, which should then be wrapped in wadding; he says it gives immediate relief from pain. He uses stronger ointments (20 to 30 per cent. in vaseline) in chronic rheumatism, lumbago, and neuralgia. He recommends it to be inhaled with steam, a tablespoonful to one or two litres of water; or to be sprayed on the throat, 5 per cent. dissolved in equal parts of ether and alcohol. He uses 1 per cent. watery emulsion in the early stages of gonorrhoea as an urethral injection, and he thinks very highly of it in eczema in 50 per cent. ointment with vaseline for adults, and 20 per cent. for children. In nascent eczema he begins with 20 per cent., and later on uses 10 per cent. He has found great advantage in obstinate eczema from an ointment made by boiling 10 parts of litharge with 30 of vinegar until 90 parts remain, and then adding 10 parts each of olive-oil, lard, and ichthyol.

857. *Currie on Chian Turpentine in Cancer*.—Currie (*Edin. Med. Jour.*, May 1883) speaks favourably of Chian turpentine, which he has used in one case of duodenal cancer, and in several cases of cancer of the uterus. In only one case was the effect negative, and then it was doubtful if the patient took the medicine regularly. In all the other cases it gave marked relief from pain, while the cachexia disappeared and the general health improved. There was no influence observed on the progress of the cancer, the effect of the drug being mainly anodyne.

858. *Burq on the Immunity of Copper-workers from Infectious Diseases*.—Burq (*Le Progrès Méd.*, No. 17, 1883) says that he demonstrated statistically, a long time ago, the immunity of workers in copper during cholera epidemics. His inquiries have shown that during the recent epidemic of typhoid fever in

Paris only two copper-workers have died. Moreover, in a society composed of three or four hundred copper-workers, which has existed for sixty years, only one member has died of an infectious disease, and that was small-pox. Burq suggests that these facts indicate an antagonism between salts of copper and the specific micro-organisms of infectious diseases, and he would give copper salts in large doses, such as Ducor's and Galippe have shown to be innocuous.

859. *Aubert on Injections of Atropine and Morphia in Anæsthesia*.—Dr. Aubert, of Lyons, recommends (*Le Progrès Méd.*, No. 17, 1883) the hypodermic injection of atropine and morphia a quarter of an hour before the administration of ether, to facilitate and expedite the anæsthesia. M. Brown-Séquard expressed his concurrence in the views expressed of the advantages of the method.

ROBERT SAUNDREY, M.D.

860. *Paczkowski on Fuchsine in Scarlatinal Nephritis*.—In the *Przegląd Lekarski*, 1882, No. 8, Dr. Paczkowski asserts that fuchsine (*fuchsanilinum muriaticum*) in daily doses, 0.05 to 0.25 gramme, given two or five days successively, invariably cures inflammatory process in the kidneys of scarlatinal patients. The author succeeded, also, in curing two cases of chronic Bright's disease by the administration of 0.2 to 0.25 gramme of the drug (in pills or solution) during a few weeks. Considerable relief of the symptoms was obtained in a third instance of the affection. [Papers on the use of fuchsine in nephritis may be found in the LONDON MEDICAL RECORD, Feb. 1881, p. 54 (Sawyer), March, p. 100 (Bertet), and May, p. 190 (Budde). Like Drs. Bergeron, Clouet, Bouchut, Devet, and J. Sawyer, Professor Renzi, of Genoa, thinks favourably of the action of fuchsine in chronic nephritis (*Virchow's Archiv*, 1880, vol. lxxx.). Professor Bamberger, also, saw a decrease in the excretion of albumen in two patients (*Wiener Med. Blätter*, April 7, 1881). Dr. A. M. Dochman, from a series of clinical observations, deduced the conclusion that fuchsine is to be recognised as one of useful symptomatic remedies in the treatment of Bright's disease. He administered the following formula: $\mathcal{R}$ Fuchsin ab arsenico depurati gr. j., sacch. albiss. gr. v. M. f. p. S.: two to four powders a day. (*Vratch*, 1881, No. 11, p. 169.) On the other hand, Dr. Mölenfeld, in the *St. Petersburg Med. Wochens.*, 1881, No. 24, obtained only negative results from the drug in his two cases of chronic parenchymatous nephritis.—*Rep.*]

861. *Woitekewicz on Salicylate of Soda in Diabetes*. The favourable results obtained by Elstein, Müller-Warneke, Wiktor, and Latham (*see* the LONDON MEDICAL RECORD, April 1881, p. 144), induced Dr. Woitekewicz (*Vratch*, 1882, No. 43) to try salicylate of soda in a case of diabetes (seemingly of malarial origin). He gave from one to three drachms a day, in solution. The administration was resumed three times. Each time a marked decrease, and at last even a temporary disappearance, of sugar from the urine was observed.

862. *Kazansky on the Treatment of Pulmonary Phthisis*.—In a paper dedicated to this subject, in the *Vracheb. Vedomosti*, 1882, Nos. 531 and 533, Dr. E. P. Kazansky insists on the importance of the antiseptic treatment of consumption. He recommends that the patient's room should be converted into a disinfectant chamber. This is best obtained by impregnating the air with the vapour of a mixture of turpentine and benzine (four parts of

turpentine to one of benzine) placed in dishes or sprinkled over the floor. Rather less effective, but still valuable, is the use of oil of eucalyptus dissolved in alcohol (one to ten) mixed with water (a teaspoonful of the alcoholic solution to half a tumbler) and diffused through a room by means of a pulverisator. The author also finds benefit in the removal of consumptive patients to fir-forests, as well as in the internal administration of turpentine, tar, &c. Inunctions of sulphur over the affected side of the chest are eulogised by him as a remedy for night-sweats and as a good expectorant. Like Dr. R. Saundby (see the LONDON MEDICAL RECORD, Dec. 1881, p. 501), Dr. Kazansky decidedly repudiates the use of opium and morphia in phthisis. Of narcotics, he employs only preparations of hyoscyamus and chloral. In common with Dr. Ordylowski (*vide* the LONDON MEDICAL RECORD, Jan. 1881, p. 12) he finds chloral of good service for allaying troublesome cough in consumption, and usually administers one or two tablespoonfuls of a solution of half a drachm to four ounces.

863. *Juk on Convallaria Majalis*.—Dr. Juk (*Proceedings of the Kieff Med. Society*, 1882, Fasc. 1) details four cases, and arrives at the following conclusions. 1. The aqueous extract of convallaria is useful in nervous disturbances of the heart's action. 2. It does not give any constant and positive results in cases of heart-disease with disturbed compensation. (It is well to add that, of the author's four cases, compensation was absent only in one patient.) 3. It does not increase the amount of urine. [Almost all other observers state that it does; see Professor Sée's paper in the *Bulletin Gén. de Thérapeutique*, July 30, 1882, and in the *Brit. Med. Jour.* Feb. 24, 1883, p. 368; Bianchi's in the LONDON MEDICAL RECORD, March 1883, p. 85; Troitzky's, *Ibid.*, April, p. 121. Still Dr. Juk stands not alone; the diuretic action of convallaria is denied, also, by Dr. Stiller, in the *Pester Med. Chir. Presse*, 1882, Nos. 47 and 48.—*Rep.*] 4. The heart's action becomes slower and more regular soon after the administration of a dose, and for this reason the extract of lilies of the valley may be used as a temporary sedative. 5. Convallaria does not possess any cumulative action, neither does it interfere with digestion.

864. *Brunner on the Disappearance of Erysipelas after Hypodermic Injection of Morphia*.—In the *Medycyna*, 1882, No. 77, Dr. M. Brunner reports the case of a hysterical woman, suffering from profuse flooding, in whom he injected hypodermically, above the pubes, an ordinary dose of ergotin. The injection was followed by severe pains, induration, and erysipelas, which, starting from the spot of puncture, rapidly spread upwards to the right hypochondrium and downwards to the knees. To relieve the pains and to prevent a threatening hystero-epileptic attack, the author injected under the skin three-fourths of a grain of morphia. He not only obtained the results desired, but, to his astonishment, cured also the erysipelas, which completely disappeared within two hours after the injection.

865. *Szeiber on the Treatment of Lupus by Iodoform*.—Dr. O. Szeiber records (*Gazeta Lekarska*, 1882, No. 27) the case of a peasant girl, aged 20, who for two and a half years suffered from ulcerative lupus of the whole nose and adjacent parts of the cheeks. The treatment adopted by him consisted in applying iodoform powder locally, twice a day. After a week's treatment, the affected parts were found

covered by young, healthy cicatricial tissue; there remained unhealed only a small ulcer on the right ala nasi, but even this showed good active granulations. The improvement was so rapid and striking as to lead the author to the opinion that iodoform is a specific for lupus. [Of a similar opinion is Dr. Riehl; see his paper on the use of iodoform in lupus in the LONDON MEDICAL RECORD, 1881, Nov., p. 458.—*Rep.*]

866. *Babaieff on Chloral in Dental Caries*.—Dr. Babaieff (*Proceedings of the Caucasian Medical Society*, 1882, No. 11) emphatically recommends, as an excellent remedy for toothache from caries, the following modification of Spörer's plan. The cavity of a destroyed tooth is washed out with tepid water or $\frac{1}{4}$ per cent. carbolic solution, and then filled with a rod made of equal parts of chloral and wax. The rods are prepared by melting wax, adding crystals of chloral to the semi-fluid mass, triturating the moisture by means of a glass pestle, and subdividing the paste as required. V. IDELSON, M.D.

867. *De Sanctis on Quinine in Large Doses in Typhoid Fever*.—Professor De Sanctis (*L'Imparziale*, March 1883) notices that at present too little attention is paid to the condition of the pulse in typhoid fever, the temperature being considered all-important. He considers this a grave error. When the pulse reaches and remains at 120 or 130, although the temperature may not be more than 39.5°C. (103°F.), the prognosis is grave. There are cases in which the temperature reaches 45°C. (105°F.), the pulse 100, and the patient recovers; and, on the contrary, the temperature is at 103°F. and the pulse 128, and the patient dies. The hyperæxia is an important fact which merits attention, but the conditions of the pulse as to power, frequency, and regularity must not be neglected. He says it is bad practice, this fashion of directing the treatment to combat solely the temperature by administering large doses of quinine, &c. One ought to adopt the principle of Dujardin-Beaumetz, that of 'armed expectation.' Quinine is often given, in the fashion coming from Germany, in doses of three to five grammes a day. Hardy has seen death take place suddenly and unexpectedly in typhoid fever after these doses. Dujardin-Beaumetz does not think death can be attributed to the quinine, as the same thing happens occasionally when quinine has not been given. If the temperature fall naturally the patient improves; but this is not the case if the fall of temperature be owing to drugs, which exert a toxic action on the organism. The temperature is lowered by these, but the patient dies. Carbolic acid, which is much used, may produce this effect. He does not wish to forbid quinine in typhoid fever, but to limit its use to thirty or forty centigrammes a day, not with the intention of combating the infection or of lowering the temperature, but to sustain the power of the heart. And if, with the daily observation of the heart and pulse, a depression of the circulation be noted, cordials and stimulants must not be spared. Thus carefully watching the case with 'armed expectation,' with plenty of fresh air, much water, and only bread and milk through the whole course of the fever, we shall not lose our patient. In typhoid fever, death too often is to be attributed to treatment.

868. *Cervello on the Physiological Action of Paraldehyde*.—Cervello says (*Archivio per le Scienze Med.*, Vol. vi., and *Il Pisani*, Disp. iv., v., and vi.) that paraldehyde is a polymeric modifica-

tion of aldehyde, and has the formula $C_9H_{13}O_3$. It is a colourless liquid, boils at about $124^\circ C.$ ($255^\circ F.$); its specific gravity is 998 at $15^\circ C.$ ($59^\circ F.$), at $10.5^\circ C.$ ($51^\circ F.$) it solidifies into fusible crystals. It is soluble in eight volumes of water at $15^\circ C.$; it is less soluble in hot water, so that the watery solution, saturated at ordinary temperatures, becomes cloudy, and at $100^\circ C.$ deposits almost half of the dissolved paraldehyde. Its anæsthetic action is not preceded by a stage of exaltation. Its action is especially exerted on the cerebral hemispheres, afterwards on the medulla oblongata and spinal cord. In large doses, it paralyses the medulla, and respiration ceases, the cardiac innervation remaining unaffected, so that the arrest of the heart is a consequence only of the arrest of the respiration; by artificial respiration, the animal may be recalled to life. These are its advantages over chloral. Its dose is double that of chloral, but varies in different individuals. As much as 10 grammes may be given to an adult without causing dangerous symptoms. It is best given in water with syrup or aromatic tincture.

869. *Morselli on the Hypnotic and Sedative Action of Paraldehyde in Mental Diseases.*—In *Il Pisani*, Disp. iv., v., vi., is a short notice of a work recently published by Prof. E. Morselli on this subject. In the forms of exaltation (mania, &c.), paraldehyde acts well, and indeed it is in these cases that it seems chiefly indicated, its action being hypnotic without depressing the circulatory system. On the disease itself it has no more effect than any other remedy. In the forms of mental depression (melancholia, &c.) paraldehyde is not so constantly successful as a hypnotic as in the former class, but often acts well. It is particularly uncertain in the forms of melancholia with excessive activity of the psycho-reflex actions. In the chronic forms of mental weakness, accompanied by agitation, paraldehyde is as useful as in acute mania. In progressive paralysis, paraldehyde is of great use in combating the agrypnia of the paralytics, especially in the periods of exaltation of the second and third stages. In hysterical states, paraldehyde also acts well as a hypnotic, but does not otherwise affect the course of the neurosis. In cases of insomnia dependent on nervous over-excitement, and maintained obstinately by the dread of not being able to sleep, the effect of paraldehyde is certain, especially if the remedy be given in a sufficient dose. Paraldehyde is not only useful in mental and nervous diseases, but also in the insomnia of other diseases, fevers, rheumatics, gout, prurigo, chloro-anæmia, &c.

870. *Comin on Purpura Hæmorrhagica produced by Sulphate of Quinine.*—Dr. Comin describes the following case in the *Gaceta de los Hospitales (El Siglo Médico)*, April 15). A woman, aged 45, suffering from tertian ague, after the second dose of quinine began to suffer on the day of remission from slight and repeated chills and headache, slight fever, general prostration, and bilious vomiting. On the next day numerous large ecchymoses—chiefly on the right arm, and forearm and cheek of the same side—were seen. With these appeared hæmatemesis, hæmaturia, and metrorrhagia. Under appropriate treatment she soon recovered. After ten days there was a fresh access of the intermittent. After the administration of quinine the same symptoms occurred. All treatment being suspended, the fever was unattended by hæmorrhage; quinine was then given

again in two attacks, with the reappearance of the symptoms. The patient was then treated with arsenic, with no appearance of the hæmorrhage.

871. *Treatment of Phthisis with Iodoform.*—Since Semmola's communication on the use of iodoform in phthisis to the International Medical Congress in Amsterdam his experiments have been repeated, and with satisfactory result. Ciaramelli, De Renzi, Fasano, and other Italians have confirmed his statements (*Lo Spallanzani*, January and February 1883). Iodoform acts in phthisis and chronic bronchial catarrh as an anæsthetic, antiseptic, and alterative. The best results are obtained in incipient phthisis, which is often cured. In advanced cases this remedy is very useful, lessening expectoration, moderating the accesses of cough and fever, and arresting the progress of caseation—in a word, prolonging the patient's life. Iodoform has been used by inhalation, either by rubbing the patient's chest with an iodoform ointment, or by making him inhale essence of turpentine containing iodoform in solution. This method, though most rational, is so largely objected to by patients and their friends because of the disagreeable smell of the iodoform, that it cannot be extensively used. Or it may be given in a pill with extract of gentian or other extract, beginning with one grain a day, increasing the dose as toleration is acquired to six or eight grains a day.

872. *Bonatti on a New Therapeutic Application of Chloral Hydrate.*—Dr. Bonatti (*Italia Medica*, March; and *Gazz. Med. Ital. Prov. Venete*, April 7) says that in the treatment of the insane one often meets with cases of obstinate constipation, in which a safe, prompt, and easily administered aperient is required. In these cases the stronger drastics, such as jalap and croton-oil, often are inefficient and dangerous. Bonatti finds that chloral in infusion of senna answers admirably. He gives it in doses of one gramme to two or even three in 100 grammes of infusion with 30 grammes of syrup. Its action is easy, safe, and powerfully drastic.

G. D'ARCY ADAMS, M.D.

873. *Sawyer on the Therapeutic Uses of Oleates.*—Dr. Sawyer, in the *Brit. Med. Jour.*, Feb. 1883, p. 250, refers to a paper read a few months ago by Dr. Shoemaker, of Philadelphia, before the Medical Society of Pennsylvania, on the preparation and uses of oleates. He claims to have introduced for the first time the use of chemically true oleates, in contradistinction to those previously prepared by the direct union of the acid with the base with or without heat. Messrs. Southall have prepared various oleates according to Dr. Shoemaker's directions. They possess the great advantage of being able to be used as dusting-powders as well as in the form of ointments; thus proving of great use in those troublesome acute and discharging affections of the skin in which greasy preparations of any kind cannot be borne.

874. *Granville on a Prescription for Acute Rheumatism.*—Dr. Mortimer Granville, in the *Brit. Med. Jour.*, April 1883, p. 663, gives a prescription which he had found very useful in cases of acute rheumatism. It is as follows:—Wrap the painful joints loosely in cotton-wool covered with flannel, and give the following mixture:— $\mathcal{R}$ Tincturæ Aconiti (P.B.), $\mathfrak{m}\mathfrak{x}\mathfrak{i}\mathfrak{j}$; Ammonii Sulphidi, $\mathfrak{m}\mathfrak{x}\mathfrak{v}\mathfrak{j}$; Aquæ Menthæ Viridis Destillatæ, $\mathfrak{z}\mathfrak{v}\mathfrak{j}$: a fourth part every four or three hours, until pain is relieved and fever abated.

875. *Carson on the Treatment of Carbuncle.*—In the *Brit. Med. Jour.*, April 1883, p. 750, Dr. Carson says that, since he has used sulphide of calcium, he has never used the knife, caustic, or anything similar in the treatment of carbuncle. It is also extremely useful in the treatment of scrofulous glands about the neck and throat, especially in suppurating glands after scarlatina (*Vide* sect. 55:3, 56:2 *Medical Digest*).

876. *Pritchard on Belladonna as a Prophylactic against Scarlet Fever.*—Mr. Pritchard, in the *Lancet*, April 1883, p. 666, writes saying that, during an epidemic of scarlet fever which lately occurred at Kingston, it was determined in the Norbiton district (where over 200 cases occurred) to put the value of belladonna as a prophylactic to the test. The dose given to children under fourteen years of age varied from one to three minims of the tincture three times a day. It was thus given to seventy-four children, of whom only 5.4 per cent. had scarlet fever, whilst those who were not put on this treatment suffered at the rate of 36.2 per cent. [Mr. Pritchard's observations bear out those of many observers noted in the *Medical Digest*, sect. 81:4, while with some belladonna finds no favour.—*Rep.*]

877. *Chapman on Distilled Water as a Vehicle for Eye-Lotions.*—Dr. Paul Chapman, in the *Practitioner*, May 1883, p. 354, suggests that in many cases, where distilled water is used in preparing eye-lotions of a soothing nature, the effect is often more irritating than otherwise. The reasons for this are stated to be that tap-water contains salt of sodium in solution, which make it slightly alkaline; and the practical deduction, which Dr. Chapman has verified, is, that the addition of two and a half grains of chloride of sodium to the ounce of distilled water, renders any lotion, intended to be of a soothing character, much more beneficial.

878. *Hay on the Value of some Nitric, Nitrous, and Nitro-Compounds in Angina Pectoris.*—Dr. Matthew Hay, in the *Practitioner*, May 1883, contributes an article bearing on an account of the successful employment of nitrite of sodium in cases of angina which appeared in the *Practitioner*, March 1883, p. 179. The conclusions at which he arrives are, briefly, 'that nitrous acid in any combination, whether as an ether or a metallic salt, is useful in the treatment of angina pectoris; and that, in the case of nitrite of amyl, the action of the acid is aided by that of the base. On the other hand, all compounds of nitric acid, whether ethereal or metallic, are without effect, unless it so happen that the constitution of the nitrate is such that it decomposes in the body with the liberation of nitrous acid. Further, nitro-substitution compounds have likewise no remedial effect. So far as at present known, the nitrogen-containing remedies for angina pectoris may be divided into two classes—*a*, consisting of combinations of nitrous acid with metallic oxides or alcoholic radicals, as nitrite of sodium and nitrite of sodium and nitrite of ethyl; *b*, comprising a peculiar class of nitric ethers obtained from the higher alcohols whose decomposition within the body results in the production of nitrous acid, of which nitro-glycerine is an example.'

879. *Sheen on Nitrite of Amyl and Nitroglycerine in Uremic Asthma.*—Dr. Sheen, in the *Brit. Med. Jour.*, April 1883, p. 811, gives brief notes on a case of a man, aged 55, who was suffering from chronic Bright's disease, and was attacked with severe dyspnoea. He was given three minims of nitrite of

amyl to inhale, and in a few minutes he was able to breathe easily and to recline in bed. Nitrite of amyl acts probably through the vaso-motor nerves, relaxing the arterioles, and thus reducing blood-pressure. Nitroglycerine is said to have much the same action, and, according to Dr. Mahomed, has a great superiority over amyl, in its gradual and more lasting effect. [In a recent case, the reporter has used with advantage sodium nitrite, strongly advocated by Dr. Hay in the *Practitioner* for 1883, p. 179, in cases of angina pectoris.]

880. *Dreschfeld on the Treatment of Phthisis by Iodoform.*—Dr. Dreschfeld, in the *Brit. Med. Jour.*, April 1883, p. 817, continues his observations, which first appeared in the *Journal* 1882, Vol. ii., p. 169. The favourable opinion then formed has been further strengthened, and the benefits claimed for this method of treatment are: 1, increase of weight; 2, increase of appetite; 3, diminution of cough and expectoration; 4, diminution, or even total cessation, of night sweats; 5, the temperature was often a little lowered. No symptoms of iodoform intoxication had ever been seen. Several medical men who have tried this treatment have obtained very satisfactory results. [Professor Semmola, of Naples, speaks very favourably of this drug in the treatment of phthisis, *vide Lancet*, Aug. 1882, p. 326. The value of iodoform insufflations in laryngeal phthisis is stated by Beetz to be great, *vide* the LONDON MEDICAL RECORD, 1882, p. 50.—*Rep.*]

881. *Hay on the Use of Concentrated Solutions of Saline Cathartics in Dropsy.*—Dr. Matthew Hay, in the *Lancet*, April 1883, p. 678, writes concerning the value of the use of a saline cathartic on the concentration of the blood. From experiments, he shows that, if the salt be given in a concentrated solution when the alimentary canal contains little or no fluid, it produces an almost immediate and very decided concentration of the blood, owing to the withdrawal of a large quantity of water therefrom. If the alimentary canal contain fluid when the salt is administered, no such concentration takes place. The excessive state of concentration does not last long, as in about an hour it begins to decline, and in four hours it becomes normal. Some hours after the administration of the salt the blood undergoes another concentration, less in degree than the first, but continuing the greater part of the day. This is due to the diuretic effect of the absorbed salt. From this double action of a concentrated saline cathartic, Dr. Hay recommends its use in cases of dropsy, and gives details of a case in which he found great benefit from a dose of three-quarters of an ounce of sulphate of magnesia dissolved in an ounce of water, in a patient with heart-disease attended with dropsy.

RICHARD NEALE, M.D.

882. *Lewin on the Use of Santonin.*—At a meeting of the Berlin Medical Society, on March 7 (*Deutsche Med. Wochens.*, March 21), Herr Lewin recommended that santonin should be prescribed in oil, as by that means it was prevented from passing into the system while yet in the stomach, and was not absorbed until it reached the intestines, where it could act more directly on the worms. He had found by experiment that santonin administered in lozenges manifested itself in the urine sixteen hours sooner than when it was given in oil.

883. *Andresse on Perchloride of Iron in Diphtheria.*—Dr. Andresse of Teltow (*Deutsche Med. Wochens.*, March 14) recommends perchloride of iron in diphtheria, a gargle of five or six drops of the liquor

to a small cupful of warm water to be used several times a day by sick and healthy alike, and the affected throat to be thoroughly brushed with the liquor, diluted with two or three times its amount of water. The throat should also be sprayed with the same dilution as is used for gargling. Internally, he prescribes a solution of quinine (one part in 120) of which a teaspoonful should be taken every hour undiluted, in order to obtain the beneficial effect of its local action.

Alice Ker, M.D.

884. *Burke on Abdominal Inunction during Pregnancy.*—Dr. Wm. C. Burke, jun., in the *New England Med. Monthly*, says:—'In the last three or four months of pregnancy all women suffer discomfort from the distension of the abdominal walls, which I have found greatly relieved by the free use, at least once a day, of some unctuous material, as vaseline or sweet lard, and in many cases the formation of the lineæ albicantes is prevented.'

OBSTETRICS AND GYNÆCOLOGY

RECENT PAPERS.

885. ECKERT, ALEXANDRA.—On Two Cases of Complete Absence of the Uterus. (*Vratch*, 1882, No. 42, pp. 714-5.)

886. BERG, A. E.—On the Pathology of Uterine Fibroids (Endometritis Myomatosa). (*Ibid.*, 1882, No. 23, pp. 371-5, and No. 94, pp. 390-2.)

887. TOLOCHINOFF, N. F.—Supravaginal Amputation of the Uterine Cervix in Cancer. (*Ibid.*, 1882, No. 22, pp. 355-6.)

888. FRASCANI.—A Case of Uræmic Dyspnoea. (*Gazz. Med. Ital. Lomb.*, April 14.)

889. TITTEL.—Nitrous Oxide as an Anæsthetic in Labour. (*Wiener Med. Blätter*, March 15.)

890. KOCHMANN.—The Treatment of Phlegmasia Dolens. (*Ibid.*, March 1.)

891. KALTENBACH.—The Treatment of Erosions of the Nipple. (*Wiener Med. Blätter*, No. 7, 1883.)

892. VERNEUIL.—Glycosuria in Nursing Women. (*Jour. de Méd. et de Chir. Prat.*, March.)

893. HOLLAND.—The Treatment of Uterine Cancer with Chian Turpentine. (*British Med. Jour.*, March, p. 560.)

894. THORBURN.—Foot-and-Mouth Disease and the Lying-in Woman. (*Lancet*, March, p. 518.)

ART. 885. *Eckert on Two Cases of Congenital Absence of the Uterus and Ovaries.*—Dr. Alexandra Eckert, in the *Vratch*, 1882, No. 42, p. 714, details two cases in which she was not able to detect any trace of the uterus or ovaries. One of the patients, a Jewess, aged 36, had been married (twice) sixteen years; the other, a Russian, aged 22, two years. Neither of them suspected that they had any sexual defect,* though they never menstruated. Both of them were of good general health, and applied to the author on account of some trifling ailment. In both of them the mammary glands and external genital parts were well and normally developed. The vaginal *cul-de-sac*, which in both of the patients lay shrunken near the introitus, on introducing a finger, showed a length of about 6 or 8 centimètres. The mucous membrane was quite smooth, void of any rugæ. [Within these few years similar cases have been reported by the following Russian authors. 1. Dr. Dochman, of Kars, in the *Mediz. Obozr.*, Feb. 1879, p. 272. The case was one of an Imeretin prostitute, aged 19; the mammae, external genitals,

and general development were normal; there was no orgasm; every three or four weeks there occurred epistaxis, lasting one or two days. 2. Dr. Grigoroff, of Moscow, *ibid.*, p. 5. The patient, aged 36, was married; she had no orgasm; there were no pubic hairs; the external genitals were like those of a girl before puberty. 3. Dr. M. Lebedeff, *ibid.*, p. 9. The patient, aged 26, had been married six years; the vaginal *cul-de-sac* was 1½ inch long; there was dyspareunia; the general health and build were excellent; the external genitals were normal; the myrtiform caruncles were well seen. 4. Dr. Tzvetkoff, *ibid.*, p. 10. The patient, aged 25, had been married eight years; she applied on account of sterility; the mammae and labia minora were imperfectly developed; her general health was good; the vagina was very narrow, 2 inches long; sexual desire was present; coition during the first years was painful, then painless. 5. Dr. G. Goldstein, of Kieff, in the *Mediz. Obozr.*, Dec. 1879, p. 783. The patient, a Jewess, aged 18, had been married one year; her general development was good; the mammary glands were normal; the labia were small, the clitoris was absent; the vaginal *cul-de-sac* was about 1 centimètre long; since the sixteenth year there occurred monthly molimina, consisting in headache, lumbar and abdominal pains, frequent calls to micturition, and erotic excitement. 6. Dr. Shonoroff, *ibid.*, p. 784. The patient was aged 16; the mammae and labia were normal; the growth of hair on the pubes was extremely scanty, the clitoris was rudimentary, the vaginal *cul-de-sac* nearly absent; there were molimina (headache, intense injection of the eyes, malaise, heart-palpitation, eczema), and monthly profuse epistaxis. 7. Dr. G. Bellin, of Charkov, in the *Vratch. Vedom.*, 1879, No. 353, p. 623. The patient, aged 48, was of strong build; the mammary glands and external genitals were perfectly normal; the vaginal *cul-de-sac* was 4 centimètres long; introitus was highly hyperæsthetic; coition *per vaginam* was always extremely painful, while irritation (rubbing) of the clitoris and labia gave her a pleasant feeling, which induced her constantly to seek male company; ultimately, from being aware of her having a sexual defect, she became a drunkard. 8. Dr. N. Prozorovsky, *ibid.*, 1880, No. 408, p. 1288. The patient, a peasant woman, aged 28, had been married eight years; she was well built; the mammary glands were rudimentary, the external genitals normal, the *cul-de-sac* about 3½ inches long; coitus was painful; there was no orgasm or sexual desire. 9. N. N., *ibid.*, No. 419, p. 1469. The patient was a prostitute, aged 22; the *cul-de-sac* was about 2 inches long; the mammary glands were large, the external genitals and general build normal; orgasm and sexual desire were rather exaggerated. See also cases of 'Absence of the Uterus,' published in the *New York Med. Record*, Dec. 10, 1881, p. 653, by Dr. Emma Ward Edwards; in the *Lancet*, Jan. 3, 1880, by Dr. J. Clay; and in the *Brit. Med. Jour.*, Dec. 11, 1880, p. 924, by Dr. Braxton Hicks.—*Rep.*]

886. *Berg on the Pathology of Uterine Fibroids (Endometritis Myomatosa).*—Dr. A. E. Berg, in the *Vratch*, 1882, Nos. 23 and 24, at considerable length details the interesting case of a patient, aged 45, who sought admission to the late Professor M. T. Horwitz's clinic on account of the enlargement of her abdomen, which had begun to grow two years before. The patient's belly resembled that of a woman in the seventh month of pregnancy. Within

the last few months before admission her menses became irregular and profuse, and she began to have slight intermenstrual hæmorrhage, but her general health remained good. A large submucous fibroid was detected. To prepare for removal of the tumour, tupelo tents were introduced into the cervical cavity, and left each time for six hours. All the while carbolic vaginal injections were daily made. On the third day after the withdrawal of the last tupelo tent there quite suddenly appeared fainting, then severe rigor, extremely obstinate muco-biliary vomiting, fever, all the signs of acute peritonitis, collapse, and, about thirty-six hours from the beginning of the symptoms, she died. At the *post mortem* examination there were found, beside an egg-shaped fibromyoma growing from the posterior uterine wall near the fundus, and measuring 16 centimètres longitudinally and 9½ centimètres transversely, fresh purulent fluid and false membranes in the peritoneal cavity, and purulent inflammation of the mucous membrane of the Fallopian tubes and the whole uterine cavity. Basing his view of the case on a careful inspection and microscopic examination of the parts, Dr. Berg comes to the conclusion that the course of the phenomena was as follows. From some unknown cause, there at first developed purulent inflammation of the mucous covering of the myoma: then the inflammation spread to the mucous membrane of the womb and tubes, purulent secretion was effused through the latter into the peritoneal cavity, and gave rise to fatal peritonitis. To mark the starting-point of the process in similar cases, the author coins the name of 'endometritis myomatosa.'

887. *Tolochinoff on Supravaginal Amputation of the Uterine Cervix in Cancer.*—The writer, in the *Vratch*, 1882, No. 22, p. 355, reports his two cases in which he successfully removed the carcinomatous vaginal portion of the cervix by supravaginal circular amputation after Schröder's method. The latter is preferred by the author to the infundibuliform method of Hegar as permitting:—1, a more complete removal of degenerated tissues, even when the neoplasm spreads to the vaginal *cul-de-sac*; and 2, an easier application of sutures, which more effectively prevents any considerable hæmorrhage. Professor Tolochinoff does not see any special danger either in the fact of Schröder's operation exposing the circumuterine cellular tissue, or in accidental (sometimes unavoidable) opening of Douglas's space. V. IDELSON, M.D.

888. *Frascani on a Case of Uræmic Dyspnœa.*—Dr. Frascani describes the following case in the *Gazz. Med. Ital. Lomb.*, April 14. A. B., aged 25, first pregnancy, had suffered from rickets in her early infancy, and had slight spinal curvature in the upper dorsal region; otherwise she was healthy. About the seventh month her legs began to swell, especially in the evening. She was admitted to the Maternity of Florence, and after being in ten days she had an attack of urgent dyspnœa. The legs were noticed to be more swollen; the urine was scanty, and contained 5 per cent. of albumen. She had tinnitus aurium, nausea, and vomiting; her sleep was broken, and she had frequent attacks of dyspnœa. As these symptoms persisted, and she was evidently becoming worse, it was determined to bring on labour; and as there seemed to be no immediate urgency, the warm douche was employed to prepare and soften the cervix. Twenty-five litres of warm carbolic solution (2½ per cent.) were thrown

up. The cervix was softened, and permitted the introduction of the finger; and the foetal head was easily felt. The next day the symptoms had rather increased: there was much dyspnœa and she had acute pain in the lumbar region. The urine was scanty, milky, and contained much albumen. The patient was much depressed. There was frequent slight uterine contraction, and the os was dilating, so that the douche was not again used. She continued in much the same state for two days, but the anasarca increased, and the urine became solid from albumen on boiling. Pulse small. She had frequent great dyspnœa. The membranes were ruptured, the head soon descended, and when it pressed on the perinæum the forceps was applied and delivery effected without difficulty. Scarcely was the child born, when she had a slight convulsion and died. The necropsy showed that all the organs were healthy with the exception of the kidneys, which were larger than normal; the capsule was easily detached without lacerating the organ; the cortical substance was white, but the pyramids retained their red colour. Parenchymatous nephritis was present.

G. D'ARCY ADAMS, M.D.

889. *Tittel on Nitrous Oxide as an Anæsthetic in Labour.*—At a meeting of the Gynecological Society in Dresden (*Wiener Med. Blätter*, March 15), Dr. Tittel gave a report of over fifty trials which he had made of the inhalation of nitrous oxide gas in parturition. He employed it chiefly in primipare with very severe pains, and found a diminution of the suffering in every case. He found it acted better when given in the first stage, as its effects lasted into the second, and quiet inhalation was more difficult when it was attempted to be given in the second stage. The pulse was generally retarded, and the foetal pulsations, on the contrary, generally accelerated. The pains were in many cases increased in strength and frequency, and Dr. Tittel found this action of the gas very serviceable in multiparæ with few and weak pains. Vomiting was arrested in four cases by the inhalation of the gas, and the only evil results which were observed were two cases of convulsions, one hysterical and the other true epileptic.

890. *Kochmann on the Treatment of Phlegmasia Dolens.*—Dr. Kochmann (*Wiener Med. Blätter*, March 1) has successfully treated a case of phlegmasia alba dolens by massage and raising of the limb until the foot is higher than the head. He begins the massage at the dorsum of the foot, and passes gradually and cautiously upwards, not attempting to touch the site of the venous thrombosis until the third sitting, when he very carefully, and with the most gentle touches, subjects it to the same treatment. The result was an immediate diminution and subsequent disappearance of pain and swelling, and the patient was able to walk on the fourth day. He lays stress on the necessity of the utmost precaution in attempting to apply massage to the site of thrombosis, for fear of causing embolism.

891. *Kaltenbach on the Treatment of Erosions of the Nipple.*—In an article on erosions of the nipple as a starting point of puerperal infection (*Wiener Med. Blätter*, No. 7, 1883), Prof. Kaltenbach of Freiburg lays especial stress on the necessity of treating the small wounds with as much care as greater ones, especially with regard to disinfection. The treatment he recommends is solution of carbolic acid, 3 to 5 per cent., with which the nipple is to be washed

in slight cases, while in severer ones a compress kept on the part will prevent excessive secretion. He does not approve of a mother ceasing to nurse her child on the occurrence of a fissure.

ALICE KER, M.D.

892. *Verneuil on Glycosuria in Nursing Women.* M. Verneuil (*Four. de Med. et de Chir. Prat.*, March 1883) has drawn attention to the presence of glycosuria in nursing women in whom lactation is suddenly suppressed, as in abscess of the breast, and he asks whether this does not explain the tendency to suppuration, diffuse inflammation, and sloughing in puerperal and nursing women. For his own part, he has for many years refused to operate during the period of lactation.

ROBERT SAUNDBY, M.D.

893. *Holland on the Treatment of Uterine Cancer with Chian Turpentine.*—Dr. E. Holland, in the *Brit. Med. Jour.*, March 1883, p. 560, writes stating that he has made careful investigations with regard to the use of Chian turpentine in a series of cases of cancer of the uterus, where the disease was well marked and left no doubt as to its malignant nature. The results may be thus summed up. None of the cases were cured; in none was the invading progress of the disease decidedly arrested. Some patients at first seemed pleased with the results and seemed cheerful, but not for long. No arrest of the disease was produced.

894. *Thorburn on Foot-and-Mouth Disease and the Lying-in Woman.*—Dr. Thorburn, in the *Lancet*, March 1883, p. 518, mentions a case of fatal metria, owing to the patient having been supplied with milk from a farm where foot-and-mouth disease was widely prevalent. All other causes of zymotic or septic poisoning were apparently capable of being eliminated; and though there was foetid lochial discharge, a careful investigation of the uterine cavity discovered nothing; repeated washings proved of no value in reducing the temperature. The sanitary surroundings of the house were excellent. Any corroborative cases on the subject would be interesting.

RICHARD NEALE, M.D.

TOXICOLOGY AND MEDICAL JURISPRUDENCE.

RECENT PAPERS.

895. KUBLY.—Defective Ossification of the Skull. (*Friedreich's Blätter für Gerichtl. Med.*, 1883, p. 123.)

896. GARNIER.—Localisation of Arsenic in the Liver. (*Ann. d'Hygiène*, 1883, Vol. ix., p. 310.)

897. OGSTON, F., JUNR.—Post Mortem Evidence of Drowning. (*Edinb. Med. Jour.*, 1882, p. 863.)

898. MITCHELL and REICHERT.—The Venoms of Serpents. (*New York Med. News*, April 28.)

899. MACNIVEN.—Poisoning by Bicarbonate of Potash. (*Glasgow Med. Jour.*, May.)

900. DREW.—Injuries of the Head in Relation to Crimes of Violence. (*Brit. Med. Jour.*, March, p. 559.)

901. SANKEY.—A Novel Method of Suppuration. (*Brit. Med. Jour.*, Jan., p. 88.)

902. MURRELL.—Intraperitoneal Injections in Cases of Poisoning. (*Lancet*, April, p. 705.)

903. ROUTH.—Poisoning by Citrate of Caffeine: Recovery. (*Ibid.*, April, p. 680.)

904. LEYDEN.—Lead-Poisoning. (*Deutsche Med. Wochens.*, March 28.)

905. MARME.—The Secretions in Morphia Poisoning. (*Deutsche Med. Wochens.*, April 4.)

ART. 895. *Kubly on Defective Ossification of the Skull.*—Dr. Kubly describes (*Friedreich's Blätter für Gerichtl. Med.*, 1883, p. 123) an interesting case of child-murder by suffocation, with which was associated a fracture of the skull through defective ossification; and also another case of fracture of the skull in a child four months old through injury where there was also defective ossification of the skull-bones, without which the injury would probably not have been of a fatal character.

896. *Garnier on Localisation of Arsenic in the Liver.*—M. Garnier (*Ann. d'Hygiène*, Vol. ix., p. 310) has investigated the vexed question of the localisation of arsenic in various organs and tissues, and has arrived at the conclusion, from his own experiments, that the liver is the organ in which the poison accumulates to the greatest amount in both acute and chronic arsenical poisoning. Relatively small quantities could be extracted from the brain when large quantities were obtained from the liver. Garnier also discusses certain theoretical considerations. Since arsenic, unlike mercury, forms no organo-metallic compound with albumen, it has been supposed that it may replace phosphorus in lecithin. Garnier thinks, however, that arsenic more probably forms insoluble arsenites and arsenates with the calcium of the fluids.

897. *Ogston on Post Mortem Evidence of Drowning.*—Dr. F. Ogston, jun., contributes an original paper (*Edinb. Med. Jour.*, 1882, p. 863) on the diagnostic value of various data for determining that death was due to drowning, and summarises his conclusions thus. 1. When an external examination of the body only is allowed, if abundance of water pour from the mouth on turning the corpse face downwards, and if white watery froth be found at the mouth and nostrils, or if it may be made to issue from them on compressing the chest, we may be justified in giving an opinion as to the probability of drowning, especially when the accessory signs—viz., rosy redness of the face and front of the chest, goose-skin, and bleaching and corrugation of the hands, are well marked; presuming always that no lethal injuries are seen on the body which would appear to have been inflicted before death, and no traces of corrosive action, &c., from poisons be observable about the lips, hands, clothes, &c.; but, to justify us in giving a more positive opinion, we ought to have furnished to us a detailed account of the locality in which, and the circumstances under which, the body was observed before its removal to the place where it lies for examination. 2. Where a complete inspection of the body is permitted, we may give a more positive opinion when, in addition to the external appearances, water in marked quantity, mixed with white watery froth, is found in the lungs and stomach, and also, perhaps, when a large quantity of watery fluid is seen in the pleural cavities; when sand, seaweed, &c., is found in the bronchi, or even in the trachea; when the lungs are bulky, or protrude on the removal of the sternum; and when the blood within the heart is wholly fluid, especially when with these signs we find marked appearances of asphyxia in the heart, lungs, liver, &c.

898. *Mitchell and Reichert on the Venoms of Serpents.*—An important research, from the Laboratory of Physiology, University of Pennsylvania, is the subject of a preliminary report by Drs. Weir Mitchell and E. T. Reichert (*New York Medical News*, April 28, 1883). The venoms experimented with were those of the cobra, rattlesnake, moccasin,

and copper-head, all of which produce in animals external symptoms which do not differ radically, save in degree. Contrary to the generally received views, these experimenters are able to show that the venoms of the mocassin and of the rattlesnake are not single venoms, but contain three proteids—one analogous to peptones, but possessed of special chemical properties, and a putrefacient; one akin to globulins, and a much more fatal poison, probably attacking the respiratory centres, and destroying the coagulating power of the blood; and a third resembling the albuminose, and probably innocent. Furthermore, they have learned that the poisons of the rattlesnake (*Crotalus adamanteus*), copper-head (*Ankistrodon contortrix*), and mocassin (*Toxophilis piscivorus*) are capable of being destroyed by bromine, iodine, thirty-three per cent. hydrobromic acid, the hydrates of potassium and sodium and, as Lacerda has shown, by potassium permanganate.

THOS. STEVENSON, M.D.

899. *Macniven on Poisoning by Bichromate of Potash*.—Macniven (*Glasgow Med. Jour.*, May 1883) reports a case of poisoning by bichromate of potash in a man aged 22. The motive was jealousy. The amount estimated to have been taken was 5j. It was taken at five o'clock one evening, 1½ hours after food. The symptoms were giddiness, pain in the stomach, vomiting, thirst, rigors, coldness of the surface, small pulse, and dilated pupils. The treatment consisted in an emetic of zinc sulphate, followed by washing out the stomach with tepid water, and a hypodermic injection of 20 minims of sulphuric ether, with a mustard poultice to the epigastrium, and warm blankets and hot bottles. The patient vomited coffee, but retained milk diluted with lime water, to which 10 grains of bismuth were added. He was allowed barley-water as drink; for diet, milk and lime-water. Next morning, he complained only of slight soreness of the mouth. He recovered without a bad symptom. The case differs from most others in the absence of purging.

ROBERT SAUNDY, M.D.

900. *Drew on Injuries of the Head in Relation to Crimes of Violence*.—Mr. Clifford Drew, in the *Brit. Med. Jour.*, March 1883, p. 559, gives his experience during the time he was resident surgeon in Milbank Convict Prison on the influence that cranial injuries had on the prisoners' career. One thing is certain, he says, that among convicts a great number of epileptics were found. The subject, however, of his paper is to open up the relationship that depressed fractures have to murderous assault and crimes of that order. A few cases are cited of criminals who suffered from attacks of uncontrollable frenzy; in each instance there was evidence of a previous injury to the head.

901. *Sankey on a Novel Method of Suffocation*.—Mr. Heurtley Sankey, in the *Brit. Med. Jour.*, January 1883, p. 88, referring to the *Journal* for Dec. 23, 1882, p. 1246, notes a case in which a patient was found dead in bed, lying on his back with a round pebble in each nostril, and a strip of flannel rolled up and stuffed into the throat.

902. *Murrell on Intraperitoneal Injections in Cases of Poisoning*.—Dr. Murrell, in the *Lancet*, April 1883, p. 705, strongly advocates Dr. Ringer's suggestion that the injection of saline solutions should be resorted to in cases of poisoning. In cases of emergency, when there is not time to prepare Dr. Ringer's solution, the following formula is recommended: Common salt, one drachm; bicar-

bonate of soda, four grains; chloride of calcium, three grains; water, twenty ounces, at a temperature of 100° F. This may be used either for intravenous or intraperitoneal injection. [Several valuable papers on intraperitoneal injections have appeared in the *LONDON MEDICAL RECORD*, 1880 and 1881, and other papers; vide *Medical Digest*, section 142:2. The dangers attending the injection of blood are treated at p. 326, *LONDON MEDICAL RECORD*, 1881.—*Rep.*]

903. *Routh on a Case of Poisoning by Citrate of Caffeine: Recovery*.—Dr. Routh, in the *Lancet*, April 1883, p. 680, gives the notes of a patient, aged 63, who took a drachm of the pure citrate of caffeine by mistake. The symptoms produced were those of a vegetable and depressant irritant, and would have proved fatal but for the violent sickness which the poison caused. There was great weakness, and marked tremors in the extremities, but no convulsions. The treatment adopted was first to encourage the vomiting, then to give stimulants to restore the cardiac syncope.

RICHARD NEALE, M.D.

904. *Leyden on Lead-Poisoning*.—In the Berlin Medical Society on March 19 (*Deutsche Med. Wochens.*, March 28), Herr Leyden reported a case of lead-poisoning, which he followed up by some remarks on the pathological anatomy of lead-palsy and of the renal affection. The patient was under observation for eighteen days in hospital, and presented specially well-marked symptoms of paralysis of the extensors, colic, constipation, albuminuria, and pains in the joints. Three attacks of loss of consciousness, unaccompanied by convulsions, came on at intervals of seven days, the third of which proved fatal. At the necropsy, recent hæmorrhage was found on the surface of the brain and in the lateral ventricles; the heart was slightly enlarged, and the wall of the left ventricle three centimetres (1½ inch) thick; the kidneys were small, the cortical substance diminished, and the pelvis enlarged. The smaller renal arteries, and to some extent the glomeruli, were in a state of hyaline degeneration; in the large arteries, hypertrophy of the inner coat was found here and there. Leyden looks upon this renal condition as peculiar to lead-poisoning, although he is unable to say why the lead should cause hyaline degeneration of the arteries, or even whether this is a constant occurrence in the disease. He considers the joint-affection to be quite independent of gout, as no deposit of salts is found, and he looks upon the cerebral effusion of blood as a consequence, not a cause, of the attacks of coma.

905. *Marmé on the Secretions in Morphia Poisoning*.—Dr. Marmé, of Göttingen, communicates (*Deutsche Med. Wochens.*, April 4), a paper on his investigations of the urine and other excretions in morphia poisoning, undertaken partly on patients, partly on animals. He finds that morphia can be recovered unaltered from the urine when the amount taken is not less than 1 centigramme (½ grain) daily. When larger doses are taken, it is found also in the feces. Instead of morphia, Dr. Marmé sometimes found 'oxydimorphin' in the excretions and in the tissues, and he found by experiment that this substance was present when a poisonous dose had been administered in very small quantities at a time, and the symptoms resembled those of the abstinence stage of morphia intoxication. From his experiments Dr. Marmé has formed the opinion that morphia may be left off suddenly in very

strong well-nourished individuals, but that in weakly persons it is necessary to diminish the dose gradually.

ALICE KER, M.D.

OPHTHALMOLOGY.

RECENT PAPERS.

906. KVASHONKIN, A.—A Case of Complete Congenital Absence of the Eyeballs. (*Vratch*, 1863, No. 1, p. 12.)
907. BARABASHEFF, N. P.—Echinococcus of the Orbit. (*Vratch*, 1882, No. 18, p. 280.)
908. HELFREICH.—Arterial Pulsation in the Retina. (*Festschrift zur Feier des 300 Bestehens der Universität zu Würzburg*.)
909. RODERO.—On the Treatment of Purulent Ophthalmia. (*Revista Estremeña*, Nov. 1882.)
910. NICOLINI.—Jequirity. (*Gazz. Med. Ital. Lombardia*, April 7 and 14.)
911. HARTRIDGE.—Boroglyceride in the Treatment of Purulent Ophthalmia. (*Lancet*, Feb. 1883, p. 273.)
912. WOLFE.—Transplantation of Skin-Flaps from Distant Parts without Pedicle. (*Practitioner*, May, p. 331.)
913. FITZPATRICK.—The Treatment of Hordeolum. (*Lancet*, April, p. 331.)
914. MARCHAND.—Bilateral Hemi-amaurosis and Hemiplegia. (*Gräfe's Archiv*, and *Centralbl. für die Med. Wiss.*, March 24.)
915. SAMELSOHN.—The Anatomy and Nosology of Retrobulbar Neuritis. (*Archiv für Ophthalm.*, Band xxviii.)
916. MAUTHNER.—The Influence of the Electric Light on the Human Eye. (*Wien. Allgem. Med. Zeit.*, No. 10, 1883.)
917. MAUTHNER.—Embolism of the Arteria Centralis Retinae. (*Wiener Med. Blätter*, March 1.)
918. KOHLER.—On Neuroparalytic Keratitis. (*Wiener Med. Blätter*, March 1.)
919. HASNER.—Paralysis of the Oculo-Motor Nerve during Menstruation. (*Wiener Med. Blätter*, March 15.)
920. HORSTMANN.—Optic Neuritis following Hæmorrhage. (*Centralbl. für die Med. Wiss.*, No. 3, 1882.)

ART. 906. *Kvashonkin on a Case of Congenital Anophthalmos Duplex*.—Dr. A. Kvashonkin describes, in the *Vratch*, 1863, No. 1, an interesting case of complete absence of both eyeballs in a boy, otherwise developed quite normally. The eyelids are shaped regularly; on their separation there is seen a shallow conjunctival *cul-de-sac*. A finger detects no trace of any rudimentary eyeball. The lacrymal glands are present; and, when the child is crying, there is an abundant flow of tears. The boy is now about one year old, well-nourished, and has six incisor teeth; and his father, mother, and two sisters are healthy.

907. *Barabasheff on Echinococcus of the Orbit*.—Dr. N. P. Barabasheff, of Charkov, reports (*Vratch*, 1882, No. 18) the case of a girl, aged twelve, in whom all the symptoms apparently pointed to a rapidly growing malignant tumour of the orbit, and indicated removal both of the neoplasm and of the eyeball. The operation was performed accordingly, but the tumour proved to be an echinococcus. The cyst had the size of a large walnut. This is the fortieth case of echinococcus of the orbit known in medical literature, and the first published in Russia.

V. IDELSON, M.D.

908. *Helbreich on Arterial Pulsation in the Retina*. Dr. Helbreich points out (*Festschrift zur Feier des 300 Bestehens der Julius-Maximilians Universität zu Würzburg*: Leipzig, 1882) that in aortic in-

sufficiency the arterial pulse is the most important and most easily recognisable phenomenon. It was observed in seven out of ten cases of this disease, whereas the so-called capillary pulsation of the optic disc (a reddening in systole and a blanching in diastole) is less frequently present and more difficult of detection. The arterial pulse could also be detected in three cases of insufficiency and stenosis of the aortic aperture. One case of both aortic and mitral insufficiency showed both arterial and capillary pulsation, whereas in another such case these phenomena were absent. The capillary pulse has been observed in aortic insufficiency once by the author, and once by Becker of Heidelberg. He considers, however, that for diagnostic purposes it has but a subordinate importance. He finds the arterial pulse wanting in pure cardiac hypertrophy. It depends upon the regurgitation of aortic blood, caused by insufficiency of the valve. When, however, the heart is at the same time hypertrophied, it strengthens this appearance. In three cases of pure stenosis of the aortic system, there were no morbid appearances. In lead-poisoning, though the characteristic increased tension was present, neither an enlargement nor a pulsation of the retinal vessels was visible.

W. A. BRAILEY, M.D.

909. *Rodero on the Treatment of Purulent Ophthalmia*.—Dr. Rodero (*Revista Estremeña*, Nov. 1882) considers the treatment by nitrate of silver to be by far the most efficacious. He uses a solution of 1 in 30, applying it thoroughly once a day. If the inflammation be high, and the conjunctiva very turgid, he scarifies it, and applies cold compresses of carbolic or boracic solution. In ulceration of the cornea he instils, three or four times a day, two or three drops of a solution of neutral sulphate of eserine (five centigrammes to fifteen grammes of distilled water), after having first washed away all discharge. The solution of nitrate of silver is to be instilled as before, and the cold antiseptic compress kept carefully and constantly applied. He thinks the value of eserine in perforation of the cornea, with prolapse of the iris, staphyloma anterior, &c., cannot be too highly rated. Atropine, which was formerly used, instead of reducing the hernia of the iris, increases its volume, rendering its excision necessary. Under the influence of eserine, the iris is freed from the edges of the wound, and instead of a staphylomatous cicatrix a perfectly flat scar remains; and even in cases of central perforation much better results are obtained from eserine, which, contracting the pupil, removes the iris from the cornea and prevents the formation of anterior synechiæ.

910. *Nicolini on Jequirity*.—Dr. Nicolini, of the Ospedale Maggiore of Milan, has tried jequirity in many cases of granular ophthalmia and pannus (*Gazz. Med. Ital. Lombardia*, April 7 and 14, 1883). His results do not confirm the statements of De Wecker. He used the infusion of the seeds prepared as De Wecker recommends, but he was careful to keep it in a stoppered bottle and not in an open vessel, and each patient was provided with his own supply, so that no contamination of the infusion could take place; he is inclined to attribute the difference of his results somewhat to this care. He finds that jequirity only excites a catarrhal state which sometimes reaches the purulent stage, but which can hardly be called a purulent conjunctivitis. This catarrh subsides spontaneously, and shortly everything is found in precisely the same state as before.

G. D'ARCY ADAMS, M.D.

911. *Hartridge on Boroglyceride in the Treatment of Purulent Ophthalmia.*—Mr. Hartridge, in the *Lancet*, Feb. 1883, p. 273, writes saying that he has recently treated some cases of purulent ophthalmia with boroglyceride, and the result has been so satisfactory that he urges a trial of this antiseptic, not only in cases of ophthalmia, but for disinfecting instruments, &c., in cataract, and other operations where a non-irritating antiseptic is required. The strength of the solution used in cases of purulent ophthalmia was 1 in 10; the eye was well brushed with this every day, whilst the lids were bathed every hour with a 1 in 40 solution. The following are some of the advantages of this antiseptic. It is readily soluble in cold or hot water; it is odourless, tasteless, and unirritating; a solution of 1 in 10 dropped into the eye causes scarcely any smarting.

912. *Wolfe on Transplantation of Skin-Flaps from Distant Parts without Pedicle.*—Dr. Wolfe, in the *Practitioner*, May 1883, p. 331, draws attention to an article published by him in the *Brit. Med. Jour.*, Sept. 18, 1875, in which he describes a method of transplanting skin-flaps from distant parts without pedicle for the purpose of correcting eversion of the eyelids. Since then the operation has been tried by several surgeons with great success, and it is with a view of applying this method to other regions besides the eye that Dr. Wolfe gives a *résumé* of his experiences with regard to it. In order to insure success it is necessary to free the piece of skin which you wish to transplant from all areolar tissue and to fix it properly in its new place. [Many of the cases to which Dr. Wolfe refers may be consulted by reference to sections 161 : 3, and 1639 : 2 of the *Medical Digest*.—Rep.]

913. *FitzPatrick on the Treatment of Hordeolum.* Mr. FitzPatrick, in the *Lancet*, April 1883, p. 715, writes stating his recent experiences in the treatment of hordeolum, or the common sty, during the time he was in Egypt. The plan of treatment adopted is to dispense with hot fomentations, &c., and to apply locally tincture of iodine to the lids, care being taken to keep them apart until dry. A few applications in the twenty-four hours is often sufficient to arrest the development of the sty. RICHARD NEALE, M.D.

914. *Marchand on Bilateral Hemi-amaurosis and Hemiplegia.*—F. Marchand, in *Gräfe's Archiv* (*Centralbl. für Med. Wiss.*, March 24), had the opportunity of *post mortem* examinations in three cases of bilateral hemi-amaurosis. In all, he found unilateral disease of the brain; in the first, a tumour in the right temporal lobe; in the second, embolism of the Sylvian artery, which had induced softening of the left optic tract; and in the third, a similar condition of the occipital lobe. The author has also collected twenty-two cases in which unilateral disease of the brain has been recorded. These he arranges under two headings—those in which the symptoms were due to lesion of the optic tract on one side; and another series in which the defect of vision was caused by a unilateral central lesion of the optic thalami and occipital lobes. Lesions of the optic tracts were found on one side in seven cases; in four there were tumours, in two softening, and in the third hæmorrhage. In three cases of lesion of the optic thalami, one was tumour, one softening, and one hæmorrhage. In twelve cases of lesions in the occipital lobes, six were softening, two from apoplectic cysts, and four were tumours. This last group included, for the most part, persons of advanced age.

915. *Samelsohn on the Anatomy and Nosology of Retrobulbar Neuritis (Amblyopia centralis).*—A. von Graefe has described under this name several forms of disease, the characteristic symptom of which is central darkness. The primary seat of the affection is to be sought in the trunk of the optic nerve, although it is not clear whether it consists in an inflammatory condition, or in a partial descending atrophy. Herr Samelsohn (*Archiv für Ophthalm.*, Band xxviii.; and *Centralbl. für die Med. Wiss.*, Dec. 16), out of six thousand six hundred and thirty-two cases of eye diseases, has noted one hundred and fifty-four of disease of the optic nerve. Of these, twenty were cases of retrobulbar neuritis, and thirty-seven of toxic amblyopia. In one case that Herr Samelsohn had observed during life, he had the opportunity of a *post mortem* examination. The patient, aged 63, died of heart-disease. The portion of the optic nerve within the cranium was examined by the microscope. The nerve-fibres at the periphery had a healthy appearance, while in the centre there were seen the results of interstitial neuritis. At its anterior portion there were traces of inflammation seen in grey atrophy of the nerve-fibres, as a result of the obstruction in the optic canal. At the point of entrance of the central vessels in the atrophic part the orifice was no longer circular, but flattened or wedge-shaped. The connective tissue was forced up into the central canal. The farther the nerve was traced from the papilla, the atrophy was found to involve the lateral fibres. The retina at this point was so thin that scarcely a trace of nerve-cells remained, while the surrounding retinal structure was normal. The atrophic process could be traced back to the districts of the convolutions of the brain forming the optic centres. Among the causes of retrobulbar neuritis are two principal groups, the influence of cold, and of poisoning by alcohol, and tobacco. These noxious agents effect morbid stimulation of the interstitial textures. The first symptom of the change consists in a cloudiness in vision; this is gradually followed by central darkness, which, however, is seldom absolute. Improvement takes place from the periphery towards the centre; the means by which this has been obtained is iodide of potassium in large doses, with gentle intoxication.

W. B. KESTEVEN, M.D.

916. *Mauthner on the Influence of the Electric Light on the Human Eye.*—In discussing the value of any particular source of artificial light, says Professor Mauthner (*Wien. Allgem. Med. Zeit.*, No. 10, 1883), three qualities must be especially regarded:—1. The steadiness of the light; 2, the strength of the light; 3, its composition. From its complete failure in point of steadiness, the arc-light must be at once rejected from the category of lights suitable for the human eye. The incandescent lamp, on the other hand, deserves a prominent—if not a leading—position. As regards its strength or intensity, also, it fulfils all requirements, since it can be modified or intensified at will. The composition of the lights habitually used hitherto has shown a preponderance of yellow rays. In the electric light, however, the short-wave rays predominate—*i.e.* the violet rays. To the human retina, blue or violet tints are more agreeable than yellow, and hence from its composition, as well as from its steadiness and adaptability, the light of the incandescent lamp is especially adapted for the use of the human eye. Distinctness of vision and the perception of colour are both increased under the electric light—facts which might be theoretically

held to involve an overstrained retina. Such a theory is not, however, borne out by practical experience; it is only where the light employed is unsteady that any ill effects have been observed. It may be considered as an established axiom, that the brilliancy and composition of any light are as nothing, in respect of its value as an illuminating medium for ordinary uses, compared with its constancy and steadiness. In the incandescent lamp no combustion takes place, and hence no consumption or vitiation of atmospheric air is induced. From a theoretic point of view, therefore, no objection can be raised against the use of the incandescent electric lamp: its full value as an illuminator is probably not yet ascertained.

E. CLIFFORD BEALE, M.B.

917. *Mauthner on Embolism of the Arteria Centralis Retinae*.—At a meeting of the Imperial and Royal Society of Vienna on Feb. 23 (*Wiener Med. Blätter*, March 1), Dr. Mauthner spoke on embolism of the arteria centralis retinae. An embolism in this situation is most often situated partly in the ophthalmic artery, whence it can be washed on into one of the other arteries, so that the supply to the retina may be kept up, and sight restored, after sudden blindness. If the embolism be entirely in the arteria centralis, it cannot go back into the ophthalmic, but may pass on into one of the branches of the central artery. The result of this will be that part of the main artery will be free, and the branches to the macula lutea, which come off early from the artery, will also be free, so that central sight, and part of the field of vision, will be re-established. As regards treatment, therefore, in quite fresh cases of embolism, pressure ought to be applied to the eyeball, so that, if the blood be prevented from passing along the central artery, and the pressure in the vessels outside the eyeball be increased, the clot has a chance of being washed into the ophthalmic by the backdraught of the stagnant blood in front of it. But, if it cannot be driven back, it must be induced to pass more forwards, out of the main trunk of the central artery, and for this purpose the intra-ocular pressure must be lessened by sclerotomy.

918. *Kohler on Neuroparalytic Keratitis*.—At a meeting of the Society of German Physicians in Prague (*Wiener Med. Blätter*, March 1) Professor Kohler described a case of neuroparalytic keratitis observed by him, which seems to support the doctrine of the neurotic nature of corneal ulcers, depending on injury to the trigeminus. There are three different theories of their occurrence: 1. Deficient protection of the eyes, and want of proper moisture; 2. Direct disturbance of nourishment, and diminished resistance, whether hyperæmia from arrest of innervation, anæmia from over action of the vaso-motor constrictors, or failure of certain trophic functions; 3. The result of irritation of the so-called trophic nerves. The case cited was that of a woman of 56, who suffered from right facial paralysis, with lagophthalmos and ectropion of the lower lid, without any affection of the cornea. A year later, when loss of sensibility appeared in the entire region of the trigeminus, a small ulcer was seen on the cornea, which, in spite of all treatment, soon spread itself over the eye, and in three or four weeks phthisis bulbi was complete.

919. *Hasner on Paralysis of the Oculo-Motor Nerve during Menstruation*.—At a meeting of the Society of German Physicians in Prague on March 2 (*Wiener Med. Blätter*, March 15) Professor

Hasner showed a case of periodical paralysis of the left oculo-motor nerve, occurring along with menstruation. The patient, a girl aged 17, was perfectly well until the first beginning of menstruation, when paralysis of the left eyelid appeared on the first day, and lasted, gradually improving, until the third day, when it disappeared with the cessation of the menses. This recurred at every menstrual period. The case seems to be unique, and Professor Hasner considers it to depend on hyperæmic pressure in the region of the root of the left oculo-motor nerve.

ALICE KER, M.D.

920. *Horstmann on Optic Neuritis following Hemorrhages*.—Horstmann (*Centralbl. für Klin. Med.*, No. 3) states that loss of sight may occur immediately after loss of blood without ophthalmoscopic changes; or changes may supervene in from three to fourteen days, when there is optic neuritis with perhaps other changes, and the result is commonly permanent amaurosis. He relates the case of a woman who in the fourth month of pregnancy suffered from a violent metrorrhagia, which was followed by partial blindness on the fourth day. After eight days there was well-marked optic neuritis, with striated hemorrhages in the retina. Five months later, there was atrophy of the optic disc, with defective vision and narrowing of the visual area.

ROBERT SAUNDBY, M.D.

DISEASES OF THE THROAT AND NOSE.

RECENT PAPERS.

921. LEFFERTS.—A Case of Syphilitic Laryngitis. (*Archives of Laryngology*, Jan. 1883.)

922. KIDD.—Congenital Syphilis of the Larynx. (*Brit. Med. Jour.*, March 17, 1883.)

923. FRÄNKEL.—Diagnosis of Tubercular Ulcer of the Larynx. (*Revue Mensuelle de Laryngologie*, Jan. 1883.)

924. ORMEROD.—Clinical Observations of the Larynx in Phthisis. (*St. Barthol. Hospital Rep.*, Vol. xviii., 1882.)

925. BREBION.—On the Velvety Aspect in the Interytenoid Space, and its Diagnostic Value in Laryngeal Phthisis. (*Lyons*, 1882, 4to.)

926. MOORE, NORMAN.—Chronic Inflammation of the Glottis. (*Brit. Med. Jour.*, Jan. 6, 1883.)

927. SCHWEIG.—Cedematous Laryngitis. (*Archives of Laryngology*, Jan. 1883.)

928. COATS AND KNOX.—Papilloma of the Larynx. (*Brit. Med. Jour.*, March 3, 1883.)

929. KNOX.—Epithelioma of the Larynx. (*Ibid.*)

930. SCHIFFERS.—Cancer of the Larynx. (*Revue Mensuelle de Laryngologie*, Jan. 1883.)

931. DELBASTAILLE.—Carcinoma of the Larynx. Extirpation of the Larynx. (*Gaz. Méd. de Strasbourg*, No. 12, 1882.)

932. BERGMANN.—Extirpation of the Larynx. (*Deutsche Med. Wochens.*, Aug. 26, 1882.)

933. JOCHELSEN.—Successful Extirpation of Larynx and Pharynx. (*Centralbl. für Chir.*, No. 37, 1882.)

934. MARGERY.—Total Extirpation of the Larynx. (*Archives Ital. di Laryngol.*, 1882.)

935. WAGNER.—Ossification of the Right Arytenoid Cartilage. (*Archives of Laryngology*, Jan. 1883.)

936. SEMON.—Removal of a Pin from the Larynx by Internal Operation. (*Brit. Med. Jour.*, April 21, 1883.)

937. DE LA SOTA.—A Bone Impacted in the Subglottic Portion of the Larynx. (*Archives of Laryngology*, Jan. 1883.)

938. KOCH.—Foreign Body Lodged at the Bifurcation of the Trachea. (*Revue Mensuelle de Laryngologie*, May 1883.)

939. GAREL.—Recent Works Relative to Nervous Aphonia or other Bilateral Paralysis of the Muscles of the Larynx.

940. SEMON.—Bilateral Paralysis of the Glottis-openers and Compression of the Trachea, in a Case of Tumour of the Thyroid Gland. (*Brit. Med. Jour.*, 1883, Vol. i., p. 542.)

941. LECOINTRE.—Isolated Paralysis of the Ary-arytenoid Muscle. (*Revue Mensuelle de Laryngologie*, Feb. 1882.)

942. SCHNITZLER.—Double Paralysis of the Recurrent Nerves. (*Monatsschr. für Ohrenheilkunde*, 8, 1882.)

943. COUPARD.—Paralysis of the Vocal Cords by Pressure of Enlarged Glands. (*Monatsschr. für Ohrenheilkunde*, No. 8, 1882.)

944. SEMON.—Differential Diagnosis of the various forms of Laryngitis in Children. (*Ibid.*, No. 10, 1882.)

945. GOIX.—Retrolaryngeal Abscess. (*Société des Sciences Médicales*.)

946. STEVENSON.—Notes on Tracheotomy. (*St. Bartholomew's Hospital Reports*, Vol. xviii., 1882.)

947. BUTLIN.—Notes on Cases from the Department of Diseases of the Larynx at St. Bartholomew's Hospital. (*Ibid.*, Vol. xviii., 1882.)

948. CHAPMAN.—Use of Cold in Diseases of the Upper Air-Passages. (*Archives of Laryngology*, Jan. 1883.)

949. MARGETSON.—A new Electric Throat-Lamp. (*Brit. Med. Jour.*, Feb. 3, 1883.)

950. MOORE, NORMAN.—Carcinoma of the Oesophagus. (*Ibid.*, Jan. 6, 1883.)

951. MARSH.—Cancerous Stricture of the Oesophagus: Gastrostomy: Death by Extension of the Disease Eight Weeks after the Operation. (*Ibid.*, March 31, 1883.)

952. PARKER.—Malignant Stricture of the Pharynx. (*Ibid.*, March 24, 1883.)

953. MACKERN.—The Treatment of Chronic Granular Pharyngitis by the Galvano-Cautic Method. (*Archives of Laryngology*, Jan. 1, 1883.)

954. MESSITER.—Hæmorrhage from the Tonsil: Ligation of Common Carotid Artery. (*Brit. Med. Jour.*, April 7, 1883.)

955. SCHRÖTTER.—Cicatricial Membranes of the Retro-nasal Cavity. (*Monatsschr. für Ohrenheilkunde*, Nov. 8, 1882.)

956. DEBLOIS.—Hypodermic Medication in Nasal Catarrh. (*Archives of Laryngology*, January 1883.)

957. BRANDEIS.—Catarrhal Headaches and Allied Affections. (*Boston Med. and Surg. Jour.*, Vol. cxviii., No. 14.)

958. BAEER.—Cases of Nasal Polypus projecting into the Naso-Pharynx. (*Lancet*, Jan. 27, 1883.)

959. TRELAT.—Case of Polypus of the Nasal Fossæ. (*Revue Mensuelle de Laryngologie*, Jan. 1883.)

ART. 921. *Lefferts on a Case of Syphilitic Laryngitis: Chondritis: Gummata of the Neck: Perforation and Formation of a complete Laryngeal Fistula: Tracheotomy: Cure.*—A man, 29 years old (*Archives of Laryngology*, Jan. 1883), contracted six years ago a chancre, followed in due time by secondary symptoms. Four years later, two large deep and intractable ulcers appeared, low down upon the posterior pharyngeal wall; they healed, and the disease remained latent until five months ago, when it made its reappearance as a diffuse gummatous infiltration on the right side of the neck. In due course ulceration occurred. Aphonia and difficulty of breathing came on. Four months afterwards, while applying a poultice, the patient noticed air escaping from the portion of the ulcer over the thyroid cartilage, and a little later coughed up a piece of the cricoid cartilage. Dr. Lefferts ascribes the fistula to the uniting of a double ulcerative action—the one beginning as a gummatous ulceration

of the neck, the other as a perichondritis around the cricoid cartilage. The edges of the fistula became unhealthy and sloughing, and necrosed cartilage was felt at its bottom. Dr. Lefferts laid it freely open, and found that it communicated with the trachea in the region of the cricoid cartilage; the anterior portion of which, together with two rings of the trachea, had been destroyed. The edges of the fistula were thoroughly scraped, and projecting and uneven portions of cartilage removed with the bone-scissors. A full-sized tracheotomy-cannula was introduced, and the fistula left to granulate. It healed soundly under the influence of iodide of potassium and biniodide of mercury in full doses; and, as soon as the condition of the larynx permitted it, the tracheal cannula was removed, when the wound rapidly closed, the patient making a good recovery.

922. *Kidd on Congenital Syphilis of the Larynx.*—Dr. Percy Kidd showed a girl aged 18 at the Royal Medical and Chirurgical Society (*Brit. Med. Jour.*, March 17, 1883). The cords were adherent at their anterior extremities by a web of a reddish grey colour. On the left was a small rounded red swelling. The cords moved freely, but the girl was almost aphonic. The epiglottis was thickened and jagged at its margins, and partially eaten away. There were other signs of congenital syphilis.

923. *Fränkel on Diagnosis of Tubercular Ulcers of the Larynx.*—Dr. Fränkel, in a paper read before the Medical Society of Berlin (*Revue Mensuelle de Laryngologie*, Jan. 1883) says that from a review of the subject we might believe it impossible to diagnose tubercular disease of the larynx. He thinks, however, that not only the characteristic, but even the rare forms, can generally be recognised. In many cases the lenticular tuberculous ulcer is quite characteristic; the tubercle is first situated altogether under the epithelium, and forms an ulceration which generally has a tendency to spread superficially. The edges are not cut, but they always allow the indentations arising from the newly infiltrated small granulations to be seen. These can be seen much more plainly on the living than on the dead. The ulcer is surrounded by an inflammatory zone, in which grey and submiliary deposits may often be discovered. In cases where the ulcer is not plain enough to be distinguished, auscultation, percussion, or the result of treatment may settle the doubt. If these fail, the laryngeal secretion must be examined for bacilli. In fifteen cases Dr. Fränkel succeeded in obtaining the secretion, and in thirteen was able to diagnose from the first examination. Care must be taken not to get any secretion from the lungs at the same time. The patient must be made to cough gently until the mucus is separated, and it can then be removed from the ulcer with a brush.

926. *Moore on Chronic Inflammation of the Glottis, Trachea, and Larynx.*—This specimen was shown by Dr. Norman Moore at the Pathological Society (*Brit. Med. Jour.*, January 6, 1883). The patient, aged 26, died of phthisis. The parts were much thickened, but no tubercle was discovered in any part of the larynx. The lungs contained tubercle and cavities.

927. *Schweig on Oedematous Laryngitis.*—The author himself was the subject of this attack (*Archives of Laryngology*, Jan. 1883), which came on after having for some weeks been attending a number of cases of diphtheria. He suffered for four days with headache and general malaise; the pharynx then became inflamed and swollen, and the larynx oedematous. There was complete inability to swallow,

Free cauterisation of the tonsils with chromic acid produced great relief, but the laryngeal oedema became more marked, and rectal alimentation was resorted to. The larynx was scarified, and all parts affected were painted with a saturated ethereal solution of iodoform. Relief was immediate, but the next day the parts were more thoroughly scarified, the iodoform continued, and recovery was complete five days after.

928. *Coats and Knox on Papilloma of the Larynx removed by Partial Thyrotomy.*—At the Glasgow Pathological and Clinical Society, Drs. Coats and Knox (*Brit. Med. Jour.*, March 3, 1883) showed a papilloma, of the size of a large bean, that had been growing from the under surface of the left vocal cord for thirteen years. The patient was 41 years old. The chief symptom was complete loss of voice. The attachment of the growth was too extensive to admit of forceps being used. Tracheotomy and plugging of the trachea having been performed, the cricoid cartilage, crico-thyroid membrane, and lower two-thirds of the thyroid cartilage were divided, and the growth removed by curved scissors without injury to the vocal cords. The voice was restored.

929. *Knox on Epithelioma of the Larynx.*—This specimen was also shown by Dr. Knox at the same meeting of the above society (*Brit. Med. Jour.*, March 3, 1883). It was taken from a man aged 26, in whom it had grown with great rapidity, causing much dyspnoea. A tracheotomy-tube had been worn some months before death. The growth had destroyed part of the cricoid cartilage, and had perforated the oesophagus.

930. *Schiffers on Cancer of the Larynx.*—Dr. Schiffers (*Revue Mensuelle de Laryngologie*, Jan. 1883) adds a contribution to our knowledge of laryngeal cancer. Symptoms are quite insufficient for diagnosis, and will probably remain so. Cachexia is seldom seen. Pain is often entirely absent. Respiratory trouble may be slight, or may not exist. Microscopic examination is often necessary. Treatment may be the only means of diagnosing by exclusion. Glandular enlargement is always present when the cancer is situated upon the external surface of the larynx; it may be entirely wanting in the case of intrinsic cancer. A man, 53 years old, first noticed hoarseness of voice in March 1881. He consulted Dr. Lefferts in November 1881, for a troublesome cough and slight muco-purulent expectoration. He had grown thin and weak. He was anæmic, but not cachectic. His constitution had been robust. There was no history of syphilis. On laryngoscopic examination, there was considerable swelling of the left side of the larynx, obscuring the vocal cord. There was no ulceration. A few days later a pinkish mass about the size of a pea was visible, a tiny piece of which was removed and found to be epithelial cancer. A large gland existed under the anterior border of the sterno-cleido-mastoid muscle, and there were several smaller ones in the left supraclavicular triangle. Nothing could be seen externally, and pressure caused no pain. Towards the middle of November, respiration became impeded. Tracheotomy was recommended, but the patient delayed entering the hospital. In December respiration became much worse, and he felt some trouble in swallowing. In a few days he died of syncope before tracheotomy had been performed. At the necropsy a voluminous tumour was found occupying the left side of the larynx, and there were secondary deposits in the lungs.

931. *Delbastaille on Carcinoma and Extirpation of the Larynx.*—Dr. Müller reports upon the above paper in the *Gaz. Méd. de Strasbourg*, No. 12, 1882. In April 1881, extirpation of the larynx was performed by Professor von Winiwarter for an adeno-carcinoma of the larynx, with diffused epithelial infiltration. There was no return eleven months after the operation. The patient did not use her artificial larynx, finding that deglutition was impeded thereby. She wore a fenestrated tracheal cannula, communicating by the opening with the pharynx, and provided with a mouth at its external orifice. She breathed quite freely and could swallow both liquids and solids with ease. Articulation was almost without sound, but was sufficiently distinct for her to be heard and understood. Of the forty-three cases of extirpation of the larynx hitherto published by Dr. Delbastaille, thirty-two have been undertaken for carcinomatous, six for sarcomatous growths, and two for tertiary syphilis. Of the six performed for the removal of sarcomata in only one has the growth returned, the other patients up to this time having remained free six years, two years, seventeen, fifteen, six, and four months respectively. In the removal of carcinomata the prognosis is less favourable; of the thirty-two cases published, there are only two in which the patient has remained free eleven months, the frequency and rapidity of the return being almost always due to the great extent of the lesion and invasion of the neighbouring parts. The mortality, moreover, is much influenced by septic pneumonia, this having been the cause of death of nearly all the patients who have succumbed in the course of the first few days after the operation. To avoid the entrance of foreign bodies into the air-passages, Dr. von Winiwarter brings the anterior wall of the oesophagus over and in front of the trachea, and fixes it with sutures to the cutaneous wound. To avoid septic pneumonia, the parts are dressed with iodoform and covered with iodoform gauze. Practised early, in the absence of glandular infiltration, and with the employment of iodoform to remove the danger of septic pneumonia, Dr. Delbastaille considers that total extirpation of the larynx should cease to be considered as an audacious experiment.

935. *Wagner on Ossification of the Right Arytenoid Cartilage: Separation and Expulsion following Thyrotomy for the Removal of a Papilloma.*—This case is reported in the *Archives of Laryngology*, January 1883. A man, aged 53, had for six months suffered from slight hoarseness, cough, and a tickling sensation in throat. A large papilloma, covering the anterior third of the right vocal cord, was discovered; but he declined to have it removed. A year later a remarkable change had taken place. He suffered from constant dyspnoea and frequent attacks of glottic spasms. The growth now covered the entire right side of the larynx. Tracheotomy and thyrotomy were performed. The thyroid cartilage was ossified, and had to be divided with a saw. While using the curette for separating the growth, Dr. Wagner was struck with the apparently thickened condition of the mucous membrane covering the anterior surface of the right arytenoid cartilage, and feared that the nucleus of a recurrent growth might exist in that locality. The patient quickly recovered from the operation. About three weeks later, Dr. Wagner observed on the anterior surface of the right arytenoid cartilage a greyish spot, which he thought was a recurrence of the growth, but which proved to be the cartilage protruding through

its coverings. The patient subsequently brought the ossified arytenoid, stating that he had expelled it during a fit of coughing.

936. *Semon on Removal by Internal Operation of a Pin from the Larynx.*—This paper was read before the Clinical Society (*Brit. Med. Jour.*, April 21, 1883). The patient was aged 13. The pin was swallowed in November 1881. No immediate serious symptoms followed; but during the next twelve months he had several paroxysms of pain in the left side of the throat, difficulty in swallowing solids, and spasmodic cough. The pin was discovered projecting about one-eighth of an inch out of the left ary-epiglottic ligament; the parts in its neighbourhood were tumefied, and the left cartilage appeared fixed. The voice was normal; there was no dyspnoea. Dr. Semon removed the pin with the forceps, but the arytenoid cartilage remained immovable. Three months after the operation, the mobility of the left half of the larynx had much improved, but Dr. Semon did not think there would be complete reparation. Special attention was called to the fact that, although there had been immobility of one half of the larynx for months there was not the slightest alteration either in the voice or respiration.

937. *De la Sota on a Bone Impacted in the Subglottic Portion of the Larynx.*—A boy (*Archives of Laryngology*, Jan. 1883) swallowed a bone while eating his supper: spasmodic attacks of cough and dyspnoea ensued. Three weeks later Dr. de la Sota saw with the laryngoscope the bone in the subglottic portion of the larynx, and tried to extract it with Fauvel's forceps, but failed. The symptoms became so severe during the following night, that tracheotomy was resorted to. For the next six or seven weeks, repeated attempts at extraction were made. At the end of that time, it was observed that the bone had changed its situation. During a spasmodic attack of coughing that same night it became dislodged, and was thought to have been swallowed. The patient was, however, unable to breathe through the larynx when the tube was closed, without bringing on the former suffocative attacks. On removing the cannula, the bone was seen lying flat at the bottom of the opening covering the posterior wall of the trachea, where the lower extremity of the cannula had stopped it. It was fortunately extracted without any accident. The bone was half a millimètre in diameter and 18 millimètres between its furthest corners, which were very sharp.

938. *Koch on a Foreign Body lodged at the Bifurcation of the Trachea.*—The patient, a woman aged 49 (*Revue Mensuelle de Laryngologie*, May 1883), while drinking soup, swallowed a piece of bone, and was almost choked. A sensation of swelling inside the throat, pain in swallowing, and spitting of blood ensued. Fifteen days afterwards slight dyspnoea came on, and the breath became fetid. Two months afterwards, on laryngoscopic examination, Dr. Koch discovered a foreign body apparently occupying the subglottic space and immovably fixed. Laryngo-tracheotomy was performed, but the crico-tracheal region was found empty. On searching lower, a bone was found at the spot where the trachea bifurcates, which by forcible coughing was expelled into the tracheal wound. Its vertical diameter was 19 millimètres, its horizontal from right to left 16, and its horizontal antero-posterior diameter 6 millimètres.

939. *Garel on some Recent Works Relative to Nervous Aphonia or other Bilateral Paralysis of*

the Muscles of the Larynx.—In seven cases published by M. Desplats (*Jour. des Sciences Méd. de Lille, Lyon Médicale*, Dec. 17, 1882) external faradisation in two cases and internal faradisation in one was followed by immediate relief of symptoms. In other cases several sittings were necessary. Galvanism has produced a marvellous effect in a number of cases where faradisation has failed. M. Massei brought forward this fact at the International Congress of Milan, and gave the following indications for their use. 1. When paralysis is of diphtheritic origin, both species of currents are applicable, but more particularly faradisation, as it acts more quickly. 2. For hysterical paralysis, each must be tried by turns; when the one has completely failed, the other may succeed. 3. The galvanic current is alone indicated in rheumatismal paralysis; as also in those forms that are the consequence of muscular efforts (artists, orators, &c.). The current must not be employed but by the intralaryngeal method; it must be feeble, the application short, and the interruptions frequent.

940. *Semon on Bilateral Paralysis of the Glottis-openers and Compression of the Trachea in a Case of Tumour of the Thyroid Gland.*—Dr. Semon showed this specimen at the Pathological Society (*Brit. Med. Jour.*, 1882, Vol. i., p. 542). It consisted of the larynx and thyroid gland removed from the body of an old gentleman. The patient had had noisy inspiration, free expiration, and unimpaired voice. The laryngoscope corroborated the symptoms. Tracheotomy was performed, and the patient shortly died. The posterior crico-arytenoids were atrophied and fatty. The paralysis was due to pressure upon the laryngeal nerves by the growth.

941. *Lecointre on Isolated Paralysis of the Ary-arytenoid Muscle.*—Dr. Lecointre (*Thèse de Bordeaux*, 1882, *Revue Mensuelle de Laryngologie*, Feb. 1882) reports ten cases of this rare affection, four of which occurred in his own practice. Seven occurred in adults. The characteristic sign by the laryngoscope was that, when the patient sounded E, the vocal cords came into contact in their two anterior thirds or anterior fourths; the posterior third or fourth remaining apart for a greater or less distance according to the degree of paralysis. Electricity directly applied to the ary-arytenoid muscle gave the best results.

945. *Goix on Retrolaryngeal Abscess.*—The author's conclusions (*Société des Sciences Médicales*) are as follows. 1. Primary acute retrolaryngeal abscess is a phlegmonous laryngitis from inflammation of the connective tissue under the lateral grooves of the larynx. 2. The symptoms are fever, pain in the larynx, hoarse and feeble voice, stenosis of the larynx and dysphagia, in a patient exempt in other respects from any affection of the larynx, pharynx, or neck. 3. The treatment consists of tartrated antimony in increasing doses; flying blisters; tracheotomy, and after tracheotomy evacuation of pus.

948. *Chapman on the Use of Cold in Diseases of the Upper Air-passages.*—Dr. Chapman's methods of applying cold (*Archives of Laryngology*, Jan. 1883) are: 1. To the exterior of the larynx by ice-bags; 2. The use of frozen wine; 3. Iced spray; 4. The double nasal catheter made like a double urethral catheter, through which a stream of very cold water may be made to run for any length of time; or a simpler and more effective method consists in the use of a very narrow and elongated inhaler packed in ice and salt through which a

stream of cold air is forced by a hand-bulb. This inhaler gives his patients a dry, cold air, like that of a clear cold winter day. The diseases for which Dr. Chapman considers the application of cold suitable are: 1. Malignant affections of the larynx, perichondritis, tubercular laryngitis, laryngeal diphtheria; 2. Acute laryngeal and pharyngeal rheumatism, a name given by Dr. Chapman to an affection found among public lecturers and others who largely use the muscles of the throat; 3. Cases of acute congestion of the upper air-passages, due to an irregular circulation and to the changeful atmosphere of spring and autumn; 4. Chronic nasal stenosis due to all causes except actual hyperplasia of tissues and abnormal formations.

949. *Margetson on an Electric Throat-Lamp.*—Dr. Margetson exhibited an electric throat-lamp at a meeting of the Leeds and West Riding Medico-Chirurgical Society (*Brit. Med. Jour.*, Feb. 3, 1883). It was of the incandescent type, and had been used by him since October last. It is about the size of a walnut, and can be held in the mouth for two minutes without discomfort.

950. *Moore on Carcinoma of the Œsophagus.*—This specimen was shown by Dr. Norman Moore at the Pathological Society (*Brit. Med. Jour.*, Jan. 6). It occurred in a man aged 56, and had given rise to symptoms for eight months. The growth had infiltrated the whole wall of the œsophagus, and was adherent to the lung at one spot where a perforation existed. The lung was here pneumonic. Twelve cases of carcinomatous stricture of the œsophagus had been examined at St. Bartholomew's in fifteen years. All were males. In six the lower, in five the middle, third was affected. In four secondary growths were found in the lungs, in one in the heart. Exhaustion was the commonest cause of death; hæmorrhage was fatal in two, pleurisy in three, gangrene in one. The ages of the patients varied from 36 to 58.

952. *Parker on Malignant Stricture of the Pharynx: Spasm of Glottis: Tracheotomy: Gastrostomy.*—This case is reported in the *Brit. Med. Jour.*, March 24, 1883. The patient was a woman aged 34. She had had difficulty in swallowing for a few weeks, and her voice was also affected. A malignant stricture was discovered at the lower part of the pharynx. Tracheotomy was performed, and subsequently gastrostomy. At the *post mortem* examination, the growth was discovered to be an epithelioma.

953. *Mackern on the Treatment of Chronic Granular Pharyngitis by the Galvano-Cautic Method.*—Dr. Mackern records (*Archives of Laryngology*, Jan. 1, 1883) cases of a severe form of this affection. They occurred in a country (Buenos Ayres) the climatic and hygienic peculiarities of which might possibly have influenced the form in which the affection manifested itself. The first patient, a lady 27 years old, otherwise healthy, had had for eight or nine years repeated attacks of tonsillitis, and continually suffered from dryness and burning sensation of the throat and weakness of voice. There was no obstruction or nasal intonation. All treatment had failed. The general surface of the posterior pharyngeal wall was pale, and was traversed by three large thin-walled veins, on the branches of which greyish elevations from one to two millimètres in diameter were situated. Very low down on the left side granulations as large as small peas, round and hard to the touch, were present. These were destroyed by the fine platinum point of Scheech's galvano-

cautery, heated to a dull red in four sittings. A good deal of pain and dysphagia followed each operation. In a few weeks the appearance of the throat had much improved, and all symptoms had disappeared. In the second case a gentleman, aged 32, had suffered for nearly two years with a continual tickling in the throat. On the posterior pharyngeal wall were a number of small granulations and numerous thin-walled veins ramifying in all directions. They were burnt off as in the preceding case, and the patient greatly benefited. In this case, after each application of the cautery, a certain number of untouched granules would disappear, which Dr. Mackern attributed to the destruction of the blood-vessels supplying them. In the third patient, a man, aged 30, the disease chiefly existed in the soft palate; the uvula was double its normal length the tip and edges gelatinous looking. Upon it was a mass of tumefactions, resembling small boils. The parts returned to their normal condition after two or three applications of the cautery. In the fourth patient, a suffocative feeling and expectoration of mucus mixed with blood had existed for twenty years. There was extensive granular disease. The granulations were not so numerous, but were of large size and peculiar appearance. Large veins were seen ramifying in various directions. The insertion of the red-hot platinum point into a large œdematous-looking granule caused an audible noise; a few drops of blood followed, the granule collapsed, and the vein became turgid. Several other similar cases have come under the observation of Dr. Mackern.

954. *Messiter on Hæmorrhage from the Tonsil: Ligature of the Common Carotid Artery.*—The author, at the Midland Medical Society (*Brit. Med. Jour.*, April 7, 1883), showed a patient in whom he had tied the common carotid artery for hæmorrhage from ulceration of the tonsil. The ascending pharyngeal was thought to be the source of the bleeding.

955. *Schrötter on Cicatricial Membranes of the Retronasal Cavity.*—The author describes (*Monatssch. für Ohrenheilkunde*, No. 8, 1882) six cases where concentric cicatrices formed a sort of diaphragm partially or completely cutting off the retronasal cavity. The most severe form occurred in a patient 32 years old. Smell, taste, hearing, and speech were affected by it. The soft palate was shrunken into a smooth reddish membrane, which ran upwards towards the base of the skull. An aperture five millimètres long and three broad, obstructed by mucus, existed on the left side, and had been made with the galvano-cautery some years before. This condition of the parts could only be seen by the rhinoscope. There was no trace of scrofula or syphilis. Professor Schrötter, by means of the galvano-cautery, made a similar hole on the right side at the situation of the posterior orifice of the right nasal passage. At the end of two days the air passed and smell returned. A metal bougie was introduced by the nostril, and allowed to remain. The next day the aperture was much larger; a bougie was now passed through the other nostril, and the two bougies tied together in front of the nose, in order to widen the aperture. Eight days afterwards, the base of the skull and the septum could be well distinguished with the rhinoscope. In the second case the cicatrix was due to syphilis, in the third to chronic blennorrhœa, in the fourth to syphilis, in the fifth to ozena; in the sixth it was doubtful.

956. *Deblouis on Hypodermic Medication in Nasal Catarrh.*—The author says (*Archives of Laryngology*,

Jan. 1883) that for nearly two years of daily treatment of nasal catarrh he has used every form of mineral and vegetable astringent without any lasting effect. He thinks their inefficacy due to the fact that the diseased membrane does not absorb the medicine properly. To obviate this he adopts a method of hypodermic injection of ergotin. He uses the following formula of Bartholow's: R ergotin, 15 minims; glycerine, 5 drachms; water, 11 drachms, modified by increasing the amount of water so that 5 minims of the injection contain $\frac{1}{12}$ grain of ergotin. He uses three shapes of needles; one straight, for direct use through the nostrils; one much curved, for use behind the soft palate; the third straight, with a small crook at the end, to reach behind any intervening object. Though this treatment has not fulfilled the author's expectations, it is very unusual not to find some effect from it. Many applications are necessary, and, in some cases, it is only by much perseverance that recovery is reached. The pain is but little. Hæmorrhage, though slight, is the most formidable obstacle, as it washes away much of the injected solution. Abscesses Dr. Deblois does not believe to have ever occurred after it. The treatment is not adapted for children; and many adults give it up from nervousness and intolerance of the slight pain. In a third class, it appears to fall short of a final and lasting effect. The author gives eight cases, of which five were apparently cured by this means; two were much relieved; one was not improved.

957. *Brandeis on Catarrhal Headaches and Allied Affections.*—In a paper read before the Medical Society of New York (*Boston Med. and Surg. Jour.*, Vol. cxviii., No. 14), Dr. Brandeis discussed the effect of acute coryza in causing headache. A gentleman, the subject of repeated attacks of acute coryza, suffered from great obstruction of the nasal passages, and the pain resulting was so intense as to cause complete prostration. The mucous membrane was very dry. The use of a few drops every hour of Hegar's fluid (carbolic acid, 1 drachm; alcohol, 3 drachms; strong aqua ammoniæ, 1 drachm; water, 2 drachms) relieved this and subsequent similar attacks very promptly. Chronic catarrhal rhinitis was also not unfrequently accompanied by more or less frontal headache. Dr. Brandeis had known of a number of cases of continued severe headaches, which were only cured after the nasal cavities had been restored to their normal condition. A lady had for ten years been scarcely free from frontal headaches. No treatment gave permanent relief. The nasal mucous membrane was thickened, and the turbinated bones considerably hypertrophied. The use of Hegar's fluid did not remove the pain. Insufflation through the middle meatus on both sides with a German sternutatory powder caused a violent attack of sneezing and profuse discharge of mucus. The symptoms were at once relieved, and permanently cured, by the same treatment, repeated at intervals of three days. In one case paroxysmal neuralgia was dependent upon hypertrophy of the turbinated bones; in another of continued headache, referred to the base of the brain and occiput, polypoid growths filled the postnasal space on both sides, the pain being relieved when these were removed.

958. *Baber on Cases of Nasal Polypus projecting into the Naso-pharynx.*—Dr. Cresswell Baber (*Lancet*, Jan. 27, 1883) relates three cases of nasal polypi projecting into the naso-pharynx. The first patient, a woman aged 32, had suffered from deafness,

vertigo, and discharge from the ears, and all her life had been subject to an offensive discharge from her nose. The left nostril was so narrowed by deflection of the septum, that the polypus could not be well seen from the front; but by posterior rhinoscopy it was discovered projecting through the left choana. Voltolini's palate-hook was employed for aiding the examination, but caused so much irritation that it could not be borne. The polypus was cut off by the cold wire snare, the loop being guided by the left forefinger introduced into the naso-pharynx. After the growth had been divided it could not be removed, owing to its size, through the nostril, and had to be pushed back into the pharynx, whence it was ejected through the mouth. The second case was similar to the preceding. A woman aged 48 had a feeling of something falling down her throat from the nose; it kept her awake, and produced great dryness of the throat. A polypus was seen occupying the upper part of the left nostril. Posterior rhinoscopy was extremely difficult, on account of the proximity of the velum to the posterior pharyngeal wall; but it was just possible to see the polypus in the left choana. Voltolini's hook could not be used. On palpation, a firm round swelling could be felt hanging down in the naso-pharynx, and was removed as in the preceding case. Two months later, the patient returned, complaining of discharge from the left nostril. After applying various remedies without avail, a small rounded swelling, of the size of a split pea, was found on the right side, attached to the septum nasi. This was successfully removed by the cold wire snare. In the third case (that of a young woman) a polypus hung down below the velum, and palpation showed that it arose from the left posterior naris. It was also removed by a wire loop, as in the former cases. It measured nearly two inches in length and one inch from side to side.

959. *Trélat on a Case of Polypus of the Nasal Fossæ.*—The patient (*Revue Mensuelle de Laryngologie*, Jan. 1883) presented a mucoid polypus of the nasal fossæ and neighbouring sinuses, which had perforated the lacrymal bone where it simulated a lacrymal tumour. M. Trélat removed the growth as follows. After making Nélaton's incision, he partially resected the superior maxillary bone, turning it outwards. He then applied the thermo-cautery to the prolongations in the maxillary, frontal, ethmoidal, and sphenoidal sinuses, and removed without any difficulty the entire growth. The wound healed by the first intention.

W. J. WALSHAM.

DISEASES OF CHILDREN.

RECENT PAPERS.

960. TILLMANN'S. Tumour and Fistula of the Umbilicus. (*Deutsche Zeitschr. für Chir.*, Band xviii.)

961. EISEN and WIDERHOFER. Melena Neonatorum. (*Allgem. Wien. Med. Zeit.*, 1882 and 1883.)

962. WEIHE.—Discharge of *Ascaris Lumbricoides* through an Umbilical Abscess. (*Berliner Klin. Wochenschr.*, Feb. 26.)

963. DEMME.—The Diagnostic Significance of Tubercular Bacilli in Childhood. (*Berliner Klin. Wochenschr.*, April 9.)

964. SOLTSMANN.—Case of *Cysticercus Cerebri* in a Child One Year Old. (*Centralbl. für die Med. Wiss.*, March 14.)

965. MORTON.—On Spina Bifida. (*Brit. Med. Jour.*, Jan. 1883, p. 82.)

966. BARLOW.—Combination of Rickets and Scurvy. (*Brit. Med. Jour.*, March, p. 619.)

967. ECKERT, ALEXANDRA.—On Invisible Cutaneous Perspiration in Children, in Health and in the Febrile State. (*Wratsh*, 1882, No. 42, p. 706.)

968. FELSNERREICH. — Laparotomy in the Newborn (*Wiener Med. Blätter*, March 22.)

969. TROISIER.—On Infantile Syphilitic Pseudo-Paralysis. (*Le Prognès Méd.*, No. 19, 1883.)

970. BIRCH-HIRSCHFELD.—The Icterus of Newborn Children. (*Virchow's Archiv*, Band lxxxvii.)

971. MEYER.—Cyanosis from Congenital Closure of the Aortic Orifice. (*New York Med. Record*, April 21.)

972. VON HOFFMANN.—The Placental Origin of Congenital Heart-Disease. (*Trans. of German Med. Congress*, No. 2.)

973. CHÉRON.—The Treatment of Vulvo-Vaginitis in Female Children. (*Jour. de Méd. de Paris*.)

ART. 960. *Tillmanns on Tumour and Fistula of the Umbilicus*.—Dr. Tillmanns, of Leipzig, reports in the *Deutsche Zeitschr. für Chir.*, Band xviii., the following case, which he believes to be unique, of congenital prolapse of gastric mucous membrane through the umbilical ring. The patient was a lad, aged 13, who presented just over the navel a tumour about the size of a walnut, and covered by deep red mucous membrane. This growth seemed to be attached to the umbilicus by a very thin pedicle. It was irreducible, and its size remained uninfluenced by coughing or by firm manual pressure over the abdomen. From the mucous surface of this tumour there was a secretion, very abundant on digital examination and after each meal, of a turbid and very viscid fluid having an acid reaction, and possessing the chemical and physiological characters of the secretion of the gastric glands. The epidermis of the skin around the tumour was macerated, and, as it were, digested by the action of this discharge. No visible orifice could be discovered on the surface of the tumour, and there was no history of any portion of fluid food or of fecal matter having ever been seen there. The tumour was first observed on the separation of the stump of the umbilical cord on the sixth day after birth. The midwife, in tying the cord, noticed that it was unusually thick near its foetal attachment. The growth increased slowly in size for about nine years, and then remained stationary. Dr. Tillmanns diagnosed this condition as one of irreducible prolapse of gastric mucous membrane, connected with the stomach by a thin and no longer permeable pedicle. Chloroform having been administered to the patient, the tumour was removed by the knife. No bad symptoms followed the operation, and the lad was soon discharged. The diagnosis was confirmed by microscopical examination of the tumour, which was found to be made up of the different coats of the stomach. The central portion was composed of the serous, subserous, and muscular layers, whilst the outer covering was formed by the mucous and submucous layers. The form of an abundant glandular element indicated that thus prolapse had taken place from the pyloric extremity of the stomach. This, Dr. Tillmanns states, had evidently been a case of congenital umbilical rupture containing a gastric diverticulum, a portion of which had been constricted by the ligature applied by the midwife to the umbilical cord, and had thus been cut off, leaving an exposed mucous surface. The pedicle, it is supposed, had been gradually reduced to a very thin cord by the pressure of the margins of the umbilical ring. Dr. Tillmanns has failed in finding any report of an analogous case. In all other cases

that have been recorded of prolapse of mucous membrane through the umbilical ring, the protruded part had been derived either from the small intestine or from a patent urachus. This paper concludes with an interesting analysis of recorded cases of such pathological conditions of the umbilicus, as are due to persistence of the vitello-intestinal duct and of the urachus.

W. JOHNSON SMITH.

961. *Epstein and Widerhofer on Melæna Neonatorum*.—Dr. Epstein, of Prague, discusses this subject (*Allgem. Wien. Med. Zeit.*, No. 49, 1882), and points out that the occurrence of hæmorrhage from the stomach and intestines of new-born children is by no means uncommon. He considers that a distinct disposition to hæmorrhage from various organs must be recognised as belonging to the first few days of life. This disposition is made manifest or increased, when either disturbance of circulation, or disease of vessels, or of the blood itself, is present. The notable alteration in the circulation which takes place at birth must therefore be regarded as a principal cause of the hæmorrhage, and especially in cases of protracted labour, or of children born in a state of partial asphyxia, or of weakly children with atelectasis of the lungs. Various conditions have been found in the gastrointestinal mucous membrane: hyperæmia, hæmorrhagic erosions, ulcerations, and actual hæmorrhage. In many cases, where the mucous membrane of the stomach has been found sprinkled with small ecchymoses, small rounded ulcers have been discovered; and these have by some authors been regarded as the real cause of melæna neonatorum, the ulcers themselves being brought about by thrombosis or embolism of the gastro-duodenal vessels, secondary to thrombosis in the umbilical vein. This is probably, however, the rarest cause for the hæmorrhage; the most common cause being the hyperæmia and temporary congestion of the finer capillary vessels. Although ulceration may take place with extreme rapidity after birth, it would appear that it is usually of intra-uterine origin; and several cases are recorded, where such ulceration has led to actual perforation of the intestine or stomach. Another group of cases is formed by those of children infected with septic diseases or the subjects of hereditary syphilis. In the latter cases the hæmorrhage may be the only evidence of the disease, the liver being found free from any syphilitic mischief. In the cases in this group, the prognosis has been clearly shown to be unfavourable. About half of the cases end fatally, and the immediate cause of death is usually the hæmorrhage itself. A few cases, however, recover with marked rapidity.

Professor Widerhofer records an interesting case of melæna neonatorum (*Allgem. Wien. Med. Zeit.*, No. 4, 1883), in which syphilitic manifestations were very distinct, and where hæmorrhages had taken place from other than mucous surfaces, the case in many respects reminding one of hæmophilia or of purpura. Such cases he regards as due to the specific affection of the blood. The prognosis is bad, and treatment by hæmostatics is of no avail.

E. CLIFFORD BEALE, M.B.

962. *Weithe on Discharge of Ascaris Lumbricoides through an Umbilical Abscess*.—Dr. Weithe, of Bad Oeynhausen, relates the following case in the *Berliner Klin. Wochenschr.*, Feb. 26. A child, four years of age, had from birth a projecting navel, which, through crying and coughing, had become still

more prominent. From four months old, the child had been subject to ulcerations of the navel which, however, readily healed. From its first year it had occasionally voided ascarides lumbricoides, in a living state, into its bed. Vermifuges were frequently given. An abscess formed at the umbilicus, the child's health being perfectly good. Hot fomentations were applied, and in three days the abscess opened spontaneously, evacuating pus, faeces, and several of the worms (ascarides lumbricoides). The fomentations were continued, and doses of santalin administered, the mother affirming that only two worms passed by the bowels after this medicine was given. About a dozen were subsequently voided through the abscess, which then rapidly healed. A fistula from the intestine had in all probability existed, and formed the channel of exit for the ascarides.

963. *Demme on the Diagnostic Significance of Tubercle-Bacilli in Childhood.*—The observations hitherto placed on record with reference to bacilli of tubercle are derived from the disease in adults. Dr. Demme, of Berne (*Berliner Klin. Wochensh.*, April 9), submits parallel researches pursued in cases of disease in children, noticing at the same time the difficulty that exists in obtaining expectoration from children under three years of age. The investigation was carried out in forty-four cases of tubercular disease. In six of these (tubercular meningitis and kidney disease) the examination was microscopic. In the remainder the sputa, or faeces, were examined a few days before death. The ages of the majority of these patients were from one to four years, and smaller proportion from five to ten years. The earliest age was eighteen weeks. It was a point of much interest and importance to watch the development of phthisical disease, from measles or whooping-cough, after the first detection of bacilli in the expectoration, and the proportional rapidity of the disease, in relation with the greater or less abundance of bacilli. In three cases of acute miliary tuberculosis, the bacilli were only discovered after death in one instance, and in the other two they were in the sputa only two or three days before death; confirming the statement of Lichtheim that the expectoration in acute miliary tuberculosis does not contain bacilli. Bacilli in considerable abundance were found in cases of lupus; also, in a case of *ozæna* in an hereditary tubercular constitution, the tubercle-bacilli were found in the mucous surface of the nostrils. This patient died, after a short illness, of tubercular meningitis. Miliary tubercles were found in the course of the vessels of the membranes, and tubercle was found in the substance of the cerebrum and cerebellum. The lungs were free from tubercular disease, as were also the abdominal viscera. In the tubercle of the pia mater, a scanty sprinkling of bacilli was found. Referring to the preceding observation, Dr. Demme remarks that tubercular disease of the mucous membrane of the nostrils is seldom, if ever, seen by itself alone. In this case, the author suggests the transmission of the bacilli from the nares by the way of the vessels to the meninges.

964. *Soltmann on a case of Cysticercus Cerebri in a Child One Year Old.*—Dr. O. Soltmann (*Centralbl. für die Med. Wiss.*, March 14) relates the following case. A child, 1 year old, was seized with vomiting, convulsions, and squinting, and suddenly died. The *post mortem* examination revealed a rickety state of

the osseous system. In the middle of the grey substance of the gyrus fornicatus was found a tumour of the size of a pea (a cysticercus); one also in the left corpus dentatum, and two smaller tumours in the cortex of the left posterior lobe on its under surface, near the fissura calcarina. No tæniæ were found in the intestines. The author finds only one case of this kind at so early an age. Fleischmann records a case of cysticercus of the brain in a child aged 2 years.

W. B. KESTEVEN, M.D.

965. *Morton on Spina Bifida.*—Dr. James Morton, in the *Brit. Med. Jour.*, Jan. 1883, p. 82, in writing on cases of spina bifida, draws attention to the extreme danger of treating these cases, but recommends early treatment by injection. Contrary to what might be expected, the injection ought to be made very carefully in lumbar cases, as the openings there into the spinal canal are large, allowing the fluid to run further than is desired. After injecting a spina bifida, it is usually necessary to wait three weeks or longer if the tumour be shrinking. The success attending this mode of treatment has been great, but extreme care is necessary in so critical an operation.

966. *Barlow on the Combination of Rickets and Scurvy.*—In the *Brit. Med. Jour.*, March 1883, p. 619, in a paper read at a meeting of the Royal Medical and Chirurgical Society, Dr. Barlow describes a disease occurring in young children, which he calls 'acute rickets.' A typical case is given in full detail. The parallelism of the disease with scurvy was shown both on anatomical and on clinical grounds. Mr. Page also recorded a case of an infant, aged 9 months, who presented subperiosteal hæmorrhages of three long bones; these, Mr. Page thought, were probably scorbutic, occurring as they did in a rickety infant, that had been fed from birth on Swiss milk and artificial foods.

RICHARD NEALE, M.D.

967. *Eckert on Invisible Cutaneous Perspiration in Healthy and Febrile Children.*—Dr. Alexandra Eckert, in the *Vratch*, 1882, No. 42, p. 706, publishes the results of her observations on thirty healthy children from two to fourteen years of age, and on twenty-seven suffering from various febrile diseases (ten cases of typhoid fever and mixed typhous forms, six of relapsing fever, four of scarlatina, three of measles, and four of chronic suppurative fever). The age of the febrile children varied from eighteen months to thirteen years. The measurements of invisible losses by the skin were taken after Weyrich's hygrometric method, somewhat modified by the author, as may be seen from her paper in the *Mejdunarodnaia Klinika*, 1882, November, pp. 1-29, in which she gives a detailed account of her experiments on healthy children. The conclusions at which the author has arrived are summed up thus.—*a. For Healthy Children.*—1. Invisible loss of water by the skin in children proceeds with greater energy than in adults. 2. The loss is greatest in children of younger age (under five years), and gradually becomes less as age, height, and weight advance. 3. All conditions being equal, any rise of barometric pressure increases loss of water by the cutaneous surface, while any increase of the humidity of the surrounding air inhibits invisible perspiration. *b. For Febrile Children.*—1. In the febrile state, invisible perspiration is augmented. 2. In enteric fever, the greatest loss of water by the skin coincides with the period of maximal mean daily temperature; afterwards invisible perspiration decreases with the

fall of febrile temperature; and, in the period of convalescence, it descends considerably below the normal level. 3. Similarly, in the course of relapsing fever, there is observed more or less considerable increase in invisible perspiration during the attacks; having reached its maximum at the time of crisis, the amount of evaporation rapidly falls, though, during the first twenty-four or thirty-six hours after the crisis, it remains still rather increased above the standard. During the apyretic intervals and after the termination of the disease cutaneous loss of water falls below the usual level. 4. In scarlatina invisible perspiration is considerably increased. [Details referring to the observations on febrile children may be found in Dr. Eckert's paper in the *Vratch*, 1883, Nos. 2, 3, 5, 7, 9, and 10. According to the author, literature contains only three special works on invisible cutaneous perspiration in children—namely, one by Dr. Vasilevsky (*St. Petersburg Inaugural Dissertation*, 1876), and two by Dr. Camerer, in the *Zeitschr. für Biologie*, 1878, vol. xiv., and 1880, vol. xvi.—*Ref.*]

V. IDELSON, M.D.

968. *Felsenreich on Laparotomy in the New-born.*—At a meeting of the Imperial and Royal Medical Society in Vienna (*Wiener Med. Blätter*, March 22), Dr. Felsenreich showed a child, two weeks old, on whom he had performed a radical operation for the cure of umbilical hernia. The birth had been easy and natural, and the child itself was strong and healthy, with no other malformation. A tumour of the size of a lemon was situated in the abdominal wall, the umbilical cord being attached to its summit. The separation between the recti muscles was eight centimètres long and four centimètres broad, and contained intestines and the margin of the liver. Twelve hours after birth, the operation was made in the usual way, the hernial sac being attached to the edge of the skin-wound, which was closed by twelve silk sutures, and dressed with iodoform. The operation was completed in twenty minutes, without much sign of pain on the part of the child, which took the breast immediately afterwards, and had a normal stool on the second day. The progress of the case was very satisfactory throughout, although the healing of the skin was somewhat slow.

ALICE KER, M.D.

969. *Troisier on Infantile Syphilitic Pseudo-Paralysis.*—Troisier (*Le Prog. Méd.*, No. 19, 1883) records a well-marked case of the pseudo-paralysis caused by an alteration in the osseous system of newly born syphilitic infants originally described by Parrot (*Arch. de Phys.*, 1871–72, p. 319; *Ibid.*, 1876, p. 133; and *Le Prog. Méd.*, 1877 and 1878). The child, aged 7 weeks, was admitted with its mother and presented well-marked signs of congenital syphilis, roseola, coryza, copper-coloured patches, alopecia, ulcers on the buttocks and face, and cachexia. The left upper extremity hung powerless, but there were feeble movements in the fingers, and when the arm was flexed and extended the biceps perceptibly contracted; this contraction could also be produced by pinching the skin of the arm; sensibility was normal. Voluntary movements persisted elsewhere; there was no facial paralysis. This state had existed eight days before admission. The child was seen by M. Parrot, who regarded it as a well-marked example of the condition described by him, the paralysis being due to the separation of the epiphysal cartilage from the upper extremity of the humerus, in consequence of syphilitic alterations in the bones. The

child died the evening of its admission. The left humerus presented an abnormal mobility of the epiphysis, and in longitudinal section the separation was obvious, the space between being filled with a purulent looking material, which under the microscope was seen to be composed of bone and cartilage cells and débris of fibro-cartilage. The epiphysis was held in position by the periosteum only. The diaphysis had undergone gelatiniform softening and atrophy of its cancellous tissue, the atrophy affecting specially the upper portion. The remainder of the bones presented slighter degrees of the same change. In addition, there were perihepatitis and perisplenitis. The brain and spinal cord were quite healthy.

970. *Birch-Hirschfeld and Hofmeier on Icterus of New-born Children.*—Birch-Hirschfeld (*Virchow's Archiv*, 1882, Band lxxvii.) attributes the icterus of newly born children to an œdema of Glisson's capsule causing compression of the bile-ducts. This œdema is the consequence of the diminution of pressure in the portal system, produced by section of the umbilical cord. This cause is favoured by weakness on the part of the infant, or delay in ligaturing the cord. This view is supported by the statements that bile-acids have been found in the pericardial fluid of children who have died in this condition; and, on the other hand, Hofmeier (*Zeitschr. für Geburtsh. und Gynäkol.*, Band viii.) regards the jaundice as both hæmatogenous and hepatogenous. The blood-corpuscles are known to be destroyed in great abundance during the first days of life, and hence arises hæmatogenous jaundice; there is also an excessive secretion of bile from this destruction, which may also irritate the bile-ducts, whence the œdema noticed by Birch-Hirschfeld. Chloroform predisposes the child to be jaundiced, by its action on the blood-corpuscles.

971. *Meyer on Cyanosis from Congenital Closure of the Aortic Orifice.*—Meyer (*New York Med. Record*, April 21, 1883) records the case of a male infant which lived twenty-seven days. It was noticed to be short of breath from birth, and in the third week became cyanosed. The dyspnoea and cyanosis increased, and when it was seen two days before death were very marked, the cyanosis extending over the whole body. There was no radial pulse, though the pulsations of the dorsalis pedis artery could be readily counted, and numbered 135. There was a loud blowing systolic murmur in the neighbourhood of the second and third ribs, to the right of the sternum. The heart was removed through a small incision, no further dissection being obtainable. The pericardium contained three-quarters of a drachm of clear serum. The heart-muscle was dark blue. The right side of the heart was dilated; the foramen ovale was patent; the pulmonary artery was twice the normal size; the ductus arteriosus was pervious; the left auricle was one-third of the size of the right; the walls of the left ventricle were half an inch thick, and its cavity was large enough to hold a small pea; the muscoli pectinati were fused into a solid mass. Mere traces of the chordæ tendinæ were to be seen. The aortic orifice was completely closed; there was no trace of the semilunar flaps. The aorta terminated at the base of the heart in a blind sac. The septum ventriculorum was complete. The circulation was carried on by the two auricles and right ventricle, the systemic circulation being supplied from the pulmonary artery by the ductus arteriosus.

ROBERT SAUNDBY, M.D.

972. *Von Hoffmann on the Placental Origin of Congenital Heart-Disease.*—Dr. Von Hoffmann records (*Trans. of German. Med. Congress*, 1882) a case of congenital closure of the semilunar valve. The child suffered at birth from cyanosis, atelectasis, and great irregularity of the heart's action, and died from suffocation on the third day. The placenta had been previously examined, and had been found to be the seat of numerous recent and old extravasations. From these hæmorrhagic foci, pathological products had been introduced through villous absorption into the foetal circulation, and had thus given rise to endocarditis. The placental extravasations had been caused by violent fits of coughing, from which the mother had suffered about the sixth month of pregnancy, which date also corresponded to the beginning of the foetal endocarditis. Von Hoffmann advises careful examination of the placenta in every case of childbirth, and believes that much light might thereby be thrown upon the etiology of diseases of the new-born.

973. *Chéron on the Treatment of Vulvo-Vaginitis in Female Children.*—M. Chéron believes (*Jour. de Méd. de Paris*) that the affection described in standard works and dictionaries under the name of 'vulvitis of female children,' is not a simple vulvitis, but always a vulvo-vaginitis. A bad state of health, due to faulty nutrition or unhealthy surroundings, and local irritation from habitually uncleanly habits, cause and encourage infantile vulvo-vaginitis. This affection is characterised by an acrid thick and yellow purulent discharge, of sometimes a greenish yellow colour. It lasts for some time, but is innocent in character, and leaves the general health uninjured. In treating such cases, the lymphatic and herpetic diathesis of the patient must be taken into consideration, and also the local condition.

MEDICAL CHEMISTRY.

RECENT PAPERS.

974. EWALD.—The Acids of the Gastric Juice. (*Virchow's Archiv*, Band xc.)

975. ROBERTS, W.—A New Test for Albumen. (*Lancet*, Oct. 14, 1882.)

976. PAVY.—Ferrocyanic Pellets as a Clinical Test for Albumen. (*Brit. Med. Jour.*, Feb. 1883, p. 308.)

977. OLIVER.—Bedside Urinary Tests. (*Lancet*, Feb. 1883, p. 190.)

978. JOHNSON.—Picric Acid as a Test for Albumen and Sugar in the Urine. (*Brit. Med. Jour.*, March, p. 504.)

979. LÉPINE AND GUÉRIN.—Incompletely Oxidised Sulphur in Urine. (*Revue de Méd.*, 1882, p. 606.)

ART. 974. *Ewald on the Acids of the Gastric Juice.* Ewald (*Virchow's Archiv*, Band xc., Heft 2), referring to Berthelot's discovery of the behaviour of acid solutions when shaken up with ether, and to Richet's application of this method to the detection of the acids of the gastric juice, says that he has not been able to confirm Richet's figures, and finds that there is no such definite and wide distinction between organic and inorganic acids in their behaviour as would permit a hard and fast line of demarcation. Moreover, he finds that, while in simple solutions these results are tolerably constant, in organic mixtures—e.g. with pepsine or serum-albumen—this is no longer so; and he comes to the

conclusion that the method is quite inapplicable to the problems Richet has tried to solve; on other grounds, he concludes that no organic acid is present in fresh pure gastric juice, and that no free leucin or leucin combined with hydrochloric acid is present in the same or in a watery extract of the gastric mucous membrane.

975. *Roberts on a New Test for Albumen.*—Dr. W. Roberts (*Lancet*, Oct. 14, 1882) recommends as a test for albumen a saturated solution of brine acidulated with a mineral acid, preferably hydrochloric. The test is applied like nitric acid by Heller's method. The precipitate produced is soluble in excess of urine. The brine test precipitates peptones from the urine and resin when copaiba is being taken. [It is recommended as being free from the objections to nitric acid, but does not appear to possess either theoretically or practically the advantages of the simple test by boiling and adding acetic acid, which is free also from the disadvantages of nitric acid, and neither precipitates peptones nor copaiba resin.—*Rep.*]

ROBERT SAUNDY, M.D.

976. *Pavy on Ferrocyanic Pellets as a Clinical Test for Albumen.*—Dr. Pavy, in the *Brit. Med. Jour.*, Feb. 1883, p. 308, communicates a paper which he sent to the Clinical Society, proposing the use of ferrocyanic test pellets to detect albumen. They are composed of sodic ferrocyanide and citric acid. All that is necessary in using the pellet is to crush it to a powdered state within a folded piece of paper, and to run the powder into an ordinary sized test-tube; the urine to be examined is poured to the height of about an inch. On simply agitating, a precipitate will appear when albumen is present.

977. *Oliver on Bedside Urinary Tests.*—Dr. G. Oliver, in the *Lancet*, Feb. 1883, p. 190, concludes an article on bedside urinary tests. Potassium ferrocyanide papers, in conjunction with citric acid, are stated to be the most reliable, compact, and portable means of detecting albumen in urine. Two new precipitants of albumen are also noticed, (a) potassio-mercurio-iodocyanide, (b) sodium tungstate. In order to neutralise acid urine, papers saturated with citric acid are used; papers saturated with picric acid have been also prepared, and have proved very successful. In conclusion, Dr. Oliver makes a few remarks on the manner of using the test-papers, and on their keeping power. Mr. Hawksley, of 357 Oxford Street, has been asked to supply a series of these papers gratuitously to any member of the profession who will put them to a careful trial, and communicate their observations to Dr. Oliver or to the *Lancet*.

978. *Johnson on Picric Acid as a Test for Albumen and Sugar in Urine.*—Dr. George Johnson, in the *Brit. Med. Jour.*, March 1883, p. 504, gives a paper in which it is shown that picric acid will detect the minutest trace of albumen. The paper also goes on to give a detailed account of the means adopted for an accurate quantitative test for sugar in urine, and a drawing is given of a new picro-saccharimeter made for Dr. Johnson by E. Cetti, of 36 Croke Street, Holborn. The accuracy of the picric acid method of volumetric sugar analysis has been fully and fairly tested. The results of this process have been compared with those obtained by Dr. Pavy's ammonio-cupric method, and were found to be practically identical; in the majority of cases the ammonio-cupric process gives results slightly in excess of the picric acid method. This

excess is due to some non-saccharine ingredients in the urine which reduce cupric oxide but not picric acid. An account of a short discussion on the paper read at the meeting of the Clinical Society will be found in the *British Medical Journal*, p. 315.

RICHARD NEALE, M.D.

979. *Lépine and Guérin on Incompletely Oxidised Sulphur in Urine*.—MM. Lépine and Guérin (*Revue de Méd.*, 1882, p. 606) have investigated the states in which sulphur exists in urine. They find that 80 per cent. of the total sulphur is present either as sulphates or as conjugated sulfo-acids, whilst 20 per cent. exists in other and little understood states. They find further that 10 or 12 per cent. of the total sulphur is in a difficultly oxidisable condition, and that for every 100 parts of nitrogen present in the healthy urine there is invariably less than 2 per cent. of sulphur in this form. In febrile diseases the proportion rises to 3 or 3.5, and in icterus to 4 or 5 parts of this difficultly oxidisable sulphur, to every 100 parts of nitrogen.

THOMAS STEVENSON, M.D.

NEW INVENTIONS.

ARTICLE 980.

FEARNLEY'S NEW METHOD OF APPLYING AIR-PRESSURE TO WOLFF'S BOTTLES.

Mr. W. FEARNLEY, May 5, writes in the *Brit. Med. Journ.* that the injection of blood-vessels plays so important a part in microscopic anatomy, healthy and morbid, and the present way of effecting it by the syringe is so difficult to acquire, and, when acquired, so uncertain in its results, that an exceedingly simple and efficacious way of doing it will be hailed with satisfaction by the profession.

The method of Ludwig has always been acknowledged as superior to injecting by the syringe, except for the one great obstacle—applying the necessary pressure—which had to be effected by elevating and depressing huge water-bottles, or by connecting the air-pressure bottle with a water-tap, and regulating the pressure as best one could, thus rendering the pressure almost as uncertain and irregular as the thumb-pressure of the syringe.

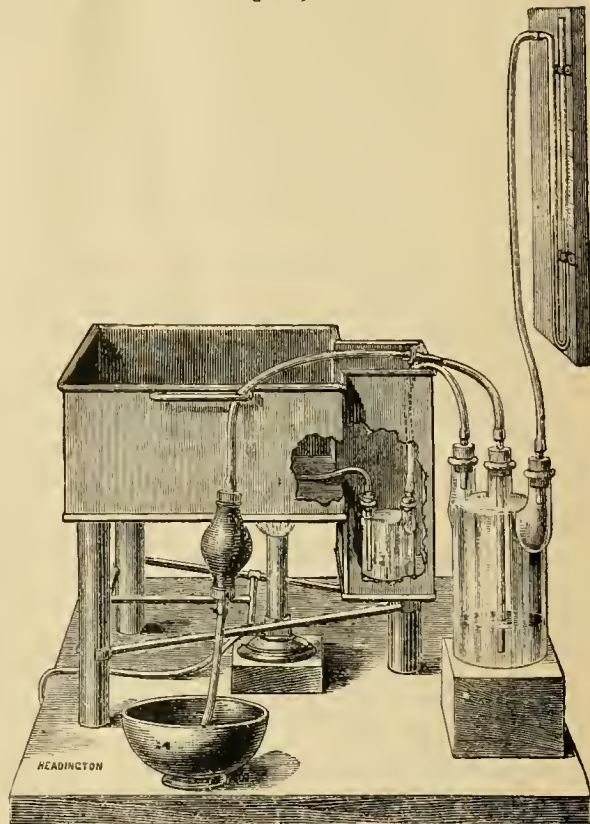
Mr. Fearnley's method is to apply the pressure with an ordinary Higginson's enema-syringe, as shown in the annexed engraving.

So even and delicate is the pressure by this method, that one arm of the mercurial manometer must be closely watched if movement of the mercury can be seen at all, whilst one entire compression of the barrel of the syringe raises the manometer a measured inch; so that, in injecting a small animal, such as a rabbit, for instance, a pint of water is amply sufficient.

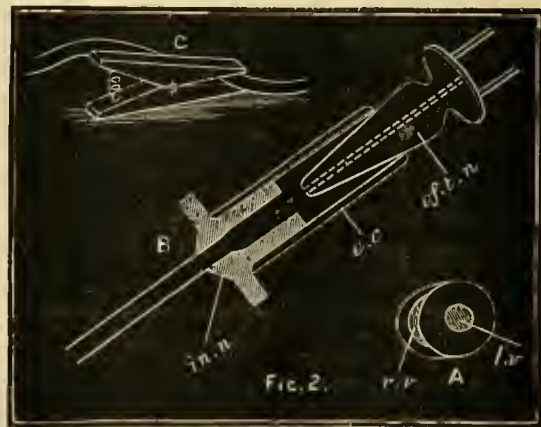
The following is Mr. Fearnley's description of the method of injection.

Suppose we decide upon injecting a rabbit, or a guinea-pig with Carter's carmine and gelatine mass, our steps are these. The bath is filled with warm water (which saves time), and a Bunsen's burner is applied beneath it to heat the water not below 100° F., and not much above 110°. Then, supposing we have our mass ready, we fill a sixteen-ounce Wolff's bottle with it, and secure the corks thoroughly, and place it in the deeper of the two departments of the bath. Not only must the mass bottle be always well immersed, but on no account is the efflux tube

for a moment to be allowed to get above the warm water, or the mass congeals, and there is a block.



Our next step is to chloroform the animal, and, immediately it is dead, to open the thorax with scissors, making an oval opening with its long axis across the thorax, taking care to keep as far as possible from the root of the neck, to avoid severing arteries that would give rise to leakage and waste of the mass. We now snip open the pericardium; seize the apex of the heart, and cut it off, when we



see the right and left ventricles, as in A, fig. 2. I use a nozzle, as in B, fig. 2, which has an elastic collar (D.C.), which is plugged by a nozzle, as here shown.

We now insert a nozzle as large or larger than the aorta, and, of course, for the arterial system, insert it in the left (round-holed) ventricle, until it appears well in the aorta. We now tie the heart-substance tightly round the nozzle with floss silk, or darning-worsted, the former being the better. On no account is hard string or thread to be used, as it either cuts the soft parts at the time of applying it, or when pressure becomes great. We now, to keep the water in the bath clear, wash out the thorax, and lift the animal into the bath, and, after allowing it to be in the hot water five minutes or so, we apply an inch of mercury pressure (*i.e.* a measured half-inch of either arm of the manometer), when, on removing the clamp on the efflux tube, C. fig. 2, air-bubbles are expelled; then comes the carmine mass, when we at once make the connection as seen in the diagram B, fig. 2. Air in the connection to interfere with the flow of the fluid is impossible, as air is displaced previously by the hot water. By seizing the animal's head with the left hand, and using our right hand in working the Higginson's syringe, the pale mouth is seen to blush, then to gradually acquire a dark red colour. We commence with a pressure of an inch of mercury, and gradually increase it up to six or even eight inches; or, taking one arm only of the manometer, from half a measured inch to four inches. This method is so simple, that I have never spoiled a single animal; indeed, one of the most famous preparers of microscopic objects, who has injected for years with the syringe, declared he had never seen an animal more beautifully injected than the very first animal (a guinea-pig) I injected by the above method. Organs are also easily injected by this method, especially when *in situ*.

The engraving is from a photograph of my apparatus, and the apparatus itself may be procured of Messrs. Swift and Son, 81 Tottenham Court Road, W.

DIETETIC NOVELTIES.

ARTICLE 981.

PURE FRENCH WINES.

HOLDING, as we do, that everything connected with the food of the people is a matter of vital interest to the medical profession, we have been induced to look into the present question of the consumption of French wines—more especially clarets—in England. The friends of temperance and dietetic reform have long been anxious to see light wine regarded, as it is in France, chiefly as an article of diet to be taken at meals. Now, if this is to be the case, one of the most important considerations is that there should be no room for doubt as to the positive genuineness of the article. We have had lately in the public press any number of statements as to the adulterations of French wines, and the fact of three or four deficient vintages in succession has no doubt had much to do with this. A late esteemed member of the medical profession (Dr. Druitt) has described the functions of claret as a beverage in the following words:—‘Bordeaux wines are of special service: they neither turn sour themselves, nor are they the cause of sourness in other articles of food. They increase the appetite, they exhilarate the spirits, and they tend to fill the veins with pure healthy blood.’ But, and it is this ‘but’ which is always cropping up, can we at the present time buy, at a moderate price, such a claret as Dr. Druitt is here speaking of? Well, we will give our readers the benefit of

our opinion upon the subject; and if in doing so we select one particular house for our illustration, it must be understood that it is solely because their extended and uniform manner of trading best suits the present purpose, although at the same time we assume that there may be many other houses who are equally correct in their dealings. Thus, taking a label of a large firm which has for many years made a feature of light wines, we find that a bottle of claret, price one shilling, is thus described:—‘This wine has been selected from wines produced in the Department of the Gironde. It possesses good body and bouquet, and its value can be proved by comparison. It is an excellent wine to drink at all times by itself, but it is softer and more satisfying when diluted with half or two-thirds of water.’ We have taken some pains to endeavour to verify the correctness of the guarantee thus given, and we are bound to say that we find the wine so guaranteed to be a perfectly sound, pure, and wholesome French wine, which, as a beverage, appears to us to answer exactly to the public requirements, to be cheap, palatable, and calculated to assimilate well with food. We are told that it is a far superior class of wine to that which forms the bulk of the *vin ordinaire* consumed abroad, and we can quite believe it. One friend, who professes to know at least a little of the trade, tells us that it cannot at the present moment be sold profitably at the price named. If so, that is the affair of Messrs. W. & A. Gilbey, and we shall be happy to leave that matter in their hands. Perhaps, however, the solution will be found in the fact that the extent of their business has necessitated their anticipating their requirements, and thus purchasing in advance of their actual immediate wants. We would only add, that so long as they and other traders can supply a fine wine such as that we have mentioned, and at a moderate price, it is of public interest to encourage its consumption, both upon grounds of health and temperance; in preference to the much stronger and less pure alcoholic liquors which still form the staple of consumption in this country.

MISCELLANY.

PRESERVATION OF VISION IN SCHOOL-CHILDREN.—Dr. Adolf Weber, in a report on the examination of eyesight in the higher schools in Darmstadt, lays great stress on the importance of the proper lighting of the schoolrooms. The windows should not reach lower than the heads of the children when standing, and where it is possible, especially in rooms for drawing or sewing, light should be admitted from the roof. Properly constructed benches and desks should be provided, and should be arranged in subdivisions according to the varying sizes of children in the same class. No class should last longer than three-quarters of an hour, and the intervening fifteen minutes should be spent in exercises for the children and in ventilating the class-rooms. The children should be carefully watched to prevent their getting into the habit of keeping their books or work nearer the eye than fourteen inches, and a reform of the writing characters (German) should be instituted. He lays stress upon the necessity of avoiding fine work, among which he mentions fine sewing, and he regards all sewing as detrimental to the children up to the age of at least 10 years. He recommends a strict medical supervision of every school, to be carried out at first by existing authorities, but eventually by a special medical officer. He finds short sight to increase very much during the school-going period of youth.



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THE TRUTH ABOUT VACCINATION.

An Examination and Refutation of the Assertions of the Anti-Vaccinators.

By **ERNEST HART,**

Chairman of the Parliamentary Bills Committee of the British Medical Association, and Chairman of the Council of the National Health Society.

EXTRACT FROM AUTHOR'S PREFACE.

'It seems needful to explain in a few words the circumstances under which this pamphlet comes to be published. I have, for several years past, been frequently appealed to, by all sorts of people, on all sorts of occasions, for a statement of the facts which would enable them to answer the strong assertions of a certain class of agitators who describe themselves as anti-vaccinators. These gentlemen are so very persistent in their agitation, and so elaborately wrong in their statistics and arguments, that it has really become a matter of no small difficulty for a technically uninstructed person to examine their figures or test their allegations.

'On the occasion of two of the most recent Parliamentary elections, I was hurriedly applied to by candidates for references to the sources from which to answer their anti-vaccinating persecutors. Members of Parliament and magistrates are, indeed, often at their wits' ends to know where to find the true facts which these gentlemen delight to misrepresent.

'I have, of course, been able to refer inquirers to the standard works on the subject, and to the Registrar-General's statistics: but a need evidently exists for some concise statement of the merits of vaccination, which will obviate the necessity of individual research into the evidence in its favour. As a matter of fact, I have not been able to refer my inquirers to any such statement, and it seemed to me, therefore, that there would be great advantage in the truth about vaccination being placed before the public in a handy and readily accessible form, so as to supply the materials for an answer to the numerous objections of the anti-vaccinators. Under these circumstances I consented, at the request of the National Health Society, to deliver a public lecture on the subject. This lecture was given at the Hall of the Society of Arts, on Jan. 27 last, and is now, in compliance with very numerous requests, printed (with considerable additions) in the present pamphlet.'

SYNOPSIS.

CHAPTER I.

SMALL-POX UNCONTROLLED BY VACCINATION.

Introduction.—Anti-vaccination tactics—Perversions and inaccuracies of anti-vaccination tracts—Small-pox in its natural state, uncontrolled by vaccination—Amongst remote communities—Among the Indians—In civilised Europe—In England—In royal and noble families—After effects of non-fatal attacks of small-pox—Macaulay's description of ravages of small-pox in seventeenth century—Introduction of inoculation and of vaccination—What vaccination is: Jenner's opinion—Power of vaccination in influencing small-pox—Modifying power of vaccination—Statistical evidence of the different degrees in which persons vaccinated in different ways will be safe against death by small-pox.

CHAPTER II.

OBJECTIONS TO VACCINATION.

The anti-vaccination creed—Reckless and absurd nature of objections—Alleged introduction of diseased matter by vaccination—Allegation that vaccination is small-poxing—M. Chauveau's experiments—their fallacy explained—Mr. Ceely's and Mr. Badcock's successes in the variolation of kine—Use of variola-vaccine lymph never followed by infection of small-pox—Inaccuracy of statement that vaccination is mainly derived from small-pox inoculation of calves—Real source of chief part of lymph in present use—Absurdity of allegation that vaccination breaks the law forbidding inoculation.

CHAPTER III.

ALLEGED MISCHIEF FROM VACCINATION, AND INCREASED MORTALITY FROM CERTAIN DISEASES.

Allegation that vaccination propagates enthetic and constitutional diseases—Source of fallacy with regard to this question—Vaccination gives immunity from small-pox only—Explanation of Mr. Hopwood's Parliamentary Return of 1877—Comparison of present with past diseases very liable to fallacy—Hypothesis that vaccination renders persons more liable to other diseases than small-pox contrary to the whole current of medical experience—Allegation that cutaneous diseases and glandular swellings are introduced by vaccination—Erysipelas after vaccination—Syphilis after vaccination—Allegations of inoculation of syphilis may easily be made in cases where there is not even a pretext for them—Practical and common-sense view of question—Experience of Medical Department of the State as to alleged injury from vaccination—Danger, if there be any at all, of communicating through vaccine lymph any other affection than its own, practically non-existent—Medical concurrence in belief of non-communicability of disease by vaccination—Opinion of Select Committee of House of Commons on the question—Animal vaccination—Its advantages.

CHAPTER IV.

SMALL-POX CONTROLLED BY VACCINATION.

Allegations that vaccination intensifies small-pox, and that it does not diminish the small-pox death-rate—London experience—

Average fatality from small-pox in Metropolis forty times greater in seventeenth and eighteenth centuries than now—Results of more general practice of vaccination—Diminution of small-pox mortality—Change in proportional fatality of small-pox at different ages, due to vaccination of young children—Increasing protection of young children from fatal small-pox—Experience of Metropolitan Asylums Hospitals in recent epidemic—Small influence of sanitary measures on small-pox.

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CHAPTER VI.

RE-VACCINATION.

Desirability of re-vaccination—Age at which it should be performed—Absolute protection afforded by re-vaccination to nurses of Small-pox Hospitals—Also to nurses and attendants of Metropolitan Asylums Hospitals—Protective influence of re-vaccination amongst soldiers and sailors—Marked decrease of small-pox mortality amongst these protected services—Concluding suggestions.

SUMMARY OF CONCLUSIONS.

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- A.—Official instructions for vaccinators under contract.
- B.—Letter of the Local Government Board on the subject of repeated vaccination prosecutions.
- C.—Table I.—Small-pox mortality in England and Wales.
- D.—Table II.—Annual mortality from small-pox in England and Wales, with the proportion of deaths to population and to total mortality, from 1838 to 1877 inclusive.
- E.—Table III.—Small-pox mortality in England and Wales at various groups of ages in each of the thirty-two years, 1847-78.
- F.—Table IV.—Cases and deaths from small-pox amongst the British troops serving in the United Kingdom for 18 years (1859-76).
- G.—Table V.—Cases and deaths from small-pox in the British Navy employed on the home force for 20 years (1859-78).

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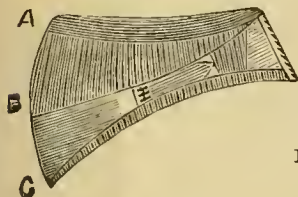
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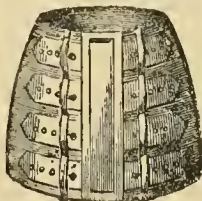
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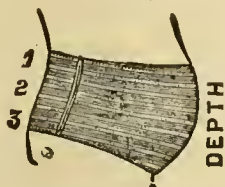
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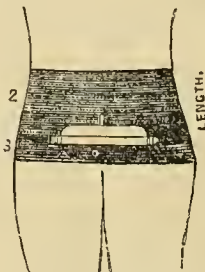


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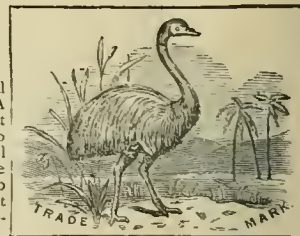
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